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Original Articles

THE OPERATIVE RELIEF OF OBSTRUCTIVE HYPERTROPHY OF THE PROSTATE

WITH AN ANALYSIS OF NINETEEN SUCCESSIVE SUCCESSFUL CASES *

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The onset of obstructive hypertrophy is usually insidious. The patient wakes more often at night and finds that he sleeps better if he empties his bladder when he wakes. Gradually a habit is formed of waking often to empty the bladder at night, so that it seems as if the patient urinated more frequently at night than during the day. The patient rises in the morning unrefreshed with the memory of a fretful, disturbed sleep. Again, the existence of a prostatic overgrowth may be first revealed to a patient by a sudden inability to pass his urine following some exposure to cold or moisture, or excessive indulgence in alcohol or coitus. The onset of cystitis with or without the added discomfort of calculus formation in the bladder are final touches to complete discomfort of the patient. The terminal stages with its degrading catheter life and gradually advancing kidney degeneration come slowly but surely, and if the obstruction be not relieved, the unfortunate owner of the prostate is condemned to a miserable and filthy invalidism, and in a relatively short time death is welcomed.

Too often the general practitioner is still swayed in his judgment as to the possibilities of relief in these cases by the experiences of a previous decade, but let me assure him that the advances made in this branch of surgery have been most tangible and brilliant, not only in the relief of the urinary obstruction, but also in bringing permanent relief from the mental and

physical degenerations associated with chronic prostatism.

PROSTATECTOMY NOT AN EMERGENCY OPERATION

Prostatectomy should never be an emergency operation. In other words, adequate preparation not only can, but should be made of the patient in every case by properly treating the bladder and kidneys before operation, and the time for enucleation of the prostate should be made to coincide with the period of greatest renal sufficiency attainable. In the earlier cases where infection of the bladder has not taken place, and a catheter can be easily inserted into the bladder, a permanent catheter may be introduced to keep the bladder continuously empty over a period of time of not less than a week. If this is done, the kidneys are relieved of the back-pressure from the bladder and there is avoided sudden relief of the pressure, which reacts directly and unfavorably on the kidneys if brought about at the time of operation and is coupled with the general and local effects of the operative traumatism.

PRELIMINARY CYSTOSTOMY

If the patient has a chronic cystitis, the indication is positive to do a preliminary suprapubic cystostomy under local anesthesia for a number of reasons. First, in those cases already suffering from constitutional disturbances, a permanent catheter is not without danger. Second, *a suprapubic opening may be made in the bladder under local anesthesia without much shock to the patient and at the same time will complete the first step for the later enucleation without the added shock of the enucleation itself.* It provides a complete drainage of the bladder; it permits of a thorough examination of the bladder and prostate, and it also provides a very efficient means of treating the bladder if it is diseased.

Another very great advantage in this preliminary cystostomy is the exposure of the tissues surrounding, or involved in, the operation wound to infection and the production of protective

* Read before the Kent County Medical Society at Grand Rapids, Michigan, May 14, 1913.

granulations in these tissues before the major operation is begun, so that if infection is to take place it will occur in the suprapubic wound before the enucleation of the prostate complicates the recovery.

Since we have adopted the two-step operation, thus managed in these cases, there has been an almost entire disappearance of the slough-encrusted suprapubic wounds, which were a usual accompaniment of the operation done at one step. The preliminary operation is done quickly under local anesthesia, and *the actual enucleation of the prostate is done after a week's interval under complete anesthesia of from five to ten minutes' duration.* If for no other reason than that this operation shortens the time of general anesthesia and can be done without using the elevated hip position in aged men, we feel that it should strongly recommend itself.

We have now a series of nineteen successive successful cases operated on by this method, the average age of these patients being about 70. In nearly every case the operation had been deferred by the patient until the disease had reached the stage where surgery was invoked as a last resort; one case having had complete obstruction for three years; one patient having complete anuria, and many cases with advanced renal disease and foul cystitis. In nearly all of the cases the age and physical condition of the patients was such that any operative interference was undertaken with questionable hope of success—and yet all of these patients entirely recovered from the operation, and regained ability to voluntarily control their bladders and empty them without the use of the catheter. In their later history two of these patients have died since the operation, one from cancer of the cecum and one from cancer of the gall-bladder, both of which conditions were known to exist at the time of the prostatectomy, but they were free from the distress due to urinary obstruction during the remaining months of their lives.

TECHNIC OF PRELIMINARY CYSTOSTOMY

The preliminary cystostomy we consider of utmost importance in these cases. It is done under local anesthesia; the bladder is opened as high up near the peritoneal fold as possible; the bladder explored with the finger, and stones, if present, removed. Then a Pezzer catheter, with its mushroom end in the bladder, is sutured in place in the wound in such a way that no urine will leak out beside it. The divided fascia, muscular planes and skin are carefully sutured together around the catheter. In this way is

accomplished the primary indication for the operation, that is, the relief of the obstruction to the outflow of urine, and this by a comparatively simple operation.

And it accomplishes something else. It exposes the suprapubic tissues to infection and allows them to fight the infection without the added irritation of the infected urine continually bathing them, and without the added depression following removal of the prostate. A reactionary period usually follows any bladder operation, during especially the second, third and fourth days. This is the greatest period of danger to the patient and, if any weakness in his economy is going to develop, it will usually show itself then. Usually these enfeebled patients have some fever and depression on the second and third day, and if renal insufficiency is a factor, it will be most marked then. By this method of procedure, then, the patient approaches the most dangerous phase of his ordeal, preceded by the minimum of surgical shock, the urinary obstruction overcome, and a perfectly drained wound. It is astonishing how uniformly these wounds heal by primary union about the Pezzer catheter. Should the patient survive this primary ordeal, the temperature falls to normal, the septic phenomena subside, the appetite returns and the general morale of the patient improves.

ENUCLEATION OF THE PROSTATE

A week after the first operation in the majority of cases the prostate may be removed. This may be accomplished in a few minutes and usually without the use of any further exposure of fresh tissue except at the neck of the bladder. An important point in the technic is leaving *in situ* all the sutures which were placed at the primary operation, especially the strong silk sutures. This allows us to dilate the wound to a considerable degree without tearing it open, and adds greatly to the rapidity with which the suprapubic wound heals. The method of enucleating the prostate varies with the individual case; both the intra-urethral enucleation and the removal of adenomatous gland entire within its capsule are practiced. After removal of the gland a catheter is passed through the urethra and the raw area from which the gland has been removed is packed tightly with narrow gauze, if there is any marked bleeding, the catheter serving as a guide and center around which the gauze is packed. A large drainage tube is introduced through the suprapubic wound and the end of the gauze packing is brought out through the tube. The wound is then carefully sutured around the drainage tube

if necessary. It will be found as a rule, that if the primary sutures are not disturbed, the wound needs no further suturing. After twenty to twenty-four hours the gauze packing is removed and the suprapubic tube is replaced by a Pezzer catheter. The urethral catheter may remain in place for twenty-four hours longer. In a few hours the Pezzer catheter can be depended on to carry off all the urine. In most cases the Pezzer catheter is removed within a week, the healing of the suprapubic wound follows promptly.

ADVANTAGES OF THE TWO-STAGE OPERATION

This operation, in two stages, seems to fill the surgical requirements of most cases better than any previous method, and we adopt it now in all cases. It is the safest for the patient, because it accomplishes its purpose with the minimum of surgical shock, requiring only a few minutes of general anesthesia, avoids the long continued sloughing-encrusted suprapubic wound, allows of a complete removal of the prostate, and a full control of the hemorrhage. I believe its adoption will greatly lower the mortality in this class of cases.

AN ILLUSTRATIVE CASE

In illustration of this method I quote the post-operative course in the last case operated on by us in a series of nineteen consecutive cases. The patient was a man 72 years of age. The primary cystostomy was done under local anesthesia with a few whiffs of chloroform. The bladder was sutured tightly around the Pezzer catheter, the suprapubic wound was carefully sutured in layers, there was no leakage around the catheter. A week later the Pezzer catheter was removed and the prostate enucleated. The primary sutures were not disturbed. The technic already described was followed. Twenty-four hours after the enucleation the packing gauze, the drainage tube and the urethral catheter were removed and the Pezzer catheter was replaced in the suprapubic wound. Normal urination was established forty-eight hours after the operation and the suprapubic wound closed four days after the primary operation and there has been no leakage therefrom since. Some of our other cases show closure of the suprapubic wound nine, eleven and fourteen days after the operation, and it is exceptional for a fistula to exist more than three weeks.

It is a practical fact that the suprapubic drain inconveniences patients to a minimum degree when managed in the manner described. It is not desirable to entirely close the bladder at once after enucleating the prostate on account of the possibilities of intercurrent hemorrhage which is

concealed if the bladder is closed. The importance of this precaution has been demonstrated by repeated experiences of our own and has been testified to by many other surgeons.

REPORT OF CASES

In reporting the following series of cases, we do so to demonstrate the excellent results which this simple technic has achieved in our hands.

CASE 1. Admitted to the Pilcher Hospital July 14, 1911. Referred by Dr. Edson of Brooklyn. Patient aged 65 years. Complete retention of urine for six months. Residual, 14 ounces. Permanent catheter four days. Suprapubic enucleation of prostate on July 17. Wound healed in twenty-one days. Complete control of urine.

Diagnosis: Adenomatous hypertrophy of the prostate.

CASE 2. Admitted to St. John's Hospital July 21, 1911. Patient aged 75 years. Seven attacks of complete retention. Residual urine 24 ounces. Foul cystitis. Preliminary cystostomy July 22. Enucleation of prostate on July 26. Time, five minutes. Wound healed in twenty-five days. Complete control.

Diagnosis: Adenomatous hypertrophy of the prostate.

CASE 3. Admitted to the Pilcher Hospital Nov. 12, 1911. Referred by Dr. H. F. Williams. Patient aged 75 years. Marked cystitis. Small residual. Preliminary cystostomy Nov. 13, 1911. Enucleation of the prostate Nov. 20, 1911—Epididymitis. Wound healed in two months. (Patient died six months after operation from carcinoma of the gall-bladder.)

Diagnosis: Adenomatous hypertrophy of prostate.

CASE 4. Admitted to St. John's Hospital Nov. 2, 1911. Partial catheter life for five years. Aged 74 years. Suprapubic cystostomy by Dr. Frank Sammis Nov. 3, 1911. Small calculus removed. Prostate enucleated Nov. 8, 1911. Wound healed in four or five weeks. One year later suprapubic cystostomy for recurrent calculi. Good recovery.

Diagnosis: Vesical calculus; adenomatous hypertrophy of prostate.

CASE 5. Admitted to the Pilcher Hospital Nov. 21, 1911. Aged 71 years. Residual 20 ounces. Suprapubic cystostomy Nov. 22, 1911. Prostate enucleated November 28. Wound closed in four weeks. Complete recovery.

Diagnosis: Adenomatous hypertrophy of prostate.

CASE 6. Admitted to St. John's Hospital Dec. 7, 1911. Aged 68 years. Previous perineal prostatectomy three years ago. Residual 6 to 8 ounces. Suprapubic cystostomy and enucleation of a middle lobe ball valve enlargement of prostate Dec. 11, 1911. Wound closed in eighteen days. Perfect recovery.

Diagnosis: Adenomatous enlargement of middle lobe of prostate.

CASE 7. Admitted to Pilcher Hospital Dec. 17, 1911. Aged 64 years. Complete retention for three years. Suprapubic cystostomy Dec. 18, 1911. Crescent shaped calculus removed. Enucleation of prostate December 23. Wound healed in about twenty-three days. Perfect recovery.

Diagnosis: Vesical calculus and adenomatous hypertrophy of prostate.

CASE 8. Admitted to Pilcher Hospital Jan. 22, 1911. Aged 60 years. Residual 12 ounces. Suprapubic cystostomy January 23. Enucleation of prostate January 27. Epididymitis. Wound healed in twenty-nine days. Perfect recovery.

Diagnosis: Adenomatous hypertrophy of prostate.
CASE 9. Admitted to Pilcher Hospital Jan. 26, 1912. Aged 68 years. Residual 10 ounces. Suprapubic cystostomy January 27. Enucleation of prostate February 3. Wound healed in nine days. Complete recovery.

Diagnosis: Adenomatous hypertrophy of prostate.

CASE 10. Admitted to Pilcher Hospital March 28, 1912. Residual 15 ounces. Aged 72 years. Suprapubic cystostomy March 29. Enucleation of prostate April 2. Secondary hemorrhage. Wound healed in twenty-one days. Perfect recovery. (Patient died ten months later of carcinoma of the cecum.)

Diagnosis: Adenomatous hypertrophy of prostate.

CASE 11. Admitted to the Pilcher Hospital May 1, 1912. Aged 67 years. Residual urine 20 ounces. Suprapubic cystostomy May 2. Enucleation of prostate May 16. Urinated voluntarily on eighth day. Wound closed in eleven days. Complete recovery.

Diagnosis: Adenomatous hypertrophy of prostate.

CASE 12. Admitted to Pilcher Hospital May 22, 1912. Aged 69 years. Residual urine 30 ounces. Permanent catheter sixteenth day. Suprapubic cystostomy and enucleation of prostate June 7. Wound closed in about two weeks. Complete recovery.

Diagnosis: Adenomatous hypertrophy of prostate.

CASE 13. Admitted to Pilcher Hospital July 10, 1912. Aged 68 years. Complete retention for two days. Suprapubic cystostomy July 10. Enucleation of prostate July 25. Secondary hemorrhage one week after operation. Packing. Repeated hemorrhages for two weeks. Bladder reopened widely and bleeding controlled by bi-polar high frequency spark applied to oozing surface. Suprapubic fistula closing slowly. Some leakage after six months when lying down. Imperfect recovery. General health good.

Diagnosis: Fibro-adenoma of the prostate.

CASE 14. Admitted to Pilcher Hospital July 17, 1912. Aged 75 years. One attack of complete retention. Suprapubic cystostomy July 18. Enucleation of prostate July 30. Wound closed in five weeks. Complete recovery.

Diagnosis: Adenomatous hypertrophy of prostate, with valve-like median lobe.

CASE 15. Admitted to Pilcher Hospital Sept. 26, 1912. Aged 52 years. Epididymitis from instrumentation. Suprapubic cystostomy and enucleation of prostate October 11. Wound healed in twenty-one days. Complete recovery.

Diagnosis: Tuberculous hypertrophy of the prostate.

CASE 16. Admitted to Pilcher Hospital Oct. 21, 1912. Aged 67 years. Complete retention four months. Permanent catheter two days. Suprapubic cystostomy and enucleation of prostate October 23. Wound closed in eighteen days. Complete recovery.

Diagnosis: Adenomatous enlargement of prostate.

CASE 17. Admitted to Pilcher Hospital Nov. 17, 1912. Aged 61. Complete retention two weeks. Suprapubic cystostomy November 18. Removal of vesical calculus. Enucleation of prostate and resection of seminal vesicles November 26. Complete recovery from operation. Wound healed in twenty-six days.

Diagnosis: Vesical calculus. Carcinoma of prostate and seminal vesicles.

CASE 18. Admitted to Pilcher Hospital Dec. 20, 1912. Aged 67 years. Suprapubic cystostomy December 21. Three small calculi removed. Enucleation of prostate December 31. Wound closed in three weeks. Complete recovery.

Diagnosis: Vesical calculi. Adenomatous hypertrophy of prostate.

CASE 19. Admitted to Pilcher Hospital March 15, 1913. Aged 73 years. Suprapubic cystostomy March 16. Enucleation of prostate March 22. Wound healed in five days. Complete recovery.

Diagnosis: Adenomatous hypertrophy of prostate. 145 Gates Avenue.

ENTEROSTOMY AND ENTEROTOMY AS LIFE-SAVING PROCEDURES

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CHICAGO

Notwithstanding the great advances that have been made in abdominal surgery and in spite of the frequent contributions to the subject of intestinal surgery, our present-day results leave much to be desired. The late diagnosis and then the efforts to obtain an intact intestinal tract, combine to maintain a high mortality. Surgery is rejected or postponed with the hope of getting a bowel function, and then the surgeon's or the patient's unwillingness to accept anything less than an ideal result leads to a fatal resection. The surgeon is not alone to blame; there are patients who would fail to appreciate being saved from a fatal ileus if they were forced thereby to face the discomfort of a fecal fistula and the horror of another operation.

Bowel complications following operations have been frequent and they have had an unnecessary mortality for the reason that necessary action on the part of the surgeon has been deterred, because a second operation would be interpreted by the patient and friends to mean that the first operation had been less than ideal if not actually harmful, and sometimes at least they would be right. Level-headed and courageous, indeed, is the surgeon who can act in the face of a disastrous post-operative ileus just as though he had not been the previous operator.

Much could be said of bowel complications in general and the means of preventing them, and we must admit the superiority of the prophylactic treatment, but my purpose is to discuss some

points of life-saving importance in those cases in which a living patient with a fecal fistula is to be preferred rather than a dead patient with an intact intestinal tract. It is a well-known fact that many forms of ileus have very little immediate significance as to life if an exit is furnished above the part affected for the escape of bowel contents. The fatality of the bowel obstruction is due largely to accumulation of, and changes in, bowel contents, above the obstruction and to their effect on the bowel wall. Even though the ileus be due to peritoneal infection, the retained bowel contents play an important part in the fatal issue whether they be retained by paralysis or by an obstruction or both, and I am led to the opinion, more and more, that there is an element of bowel obstruction in most cases of severe peritoneal infection—that instead of paralysis existing alone the bowel is kinked, compressed, strictured by bands, etc., to the extent that retained bowel contents furnish a strong ally to the infection outside the bowel.

Under normal conditions peristalsis is favored by the presence of a moderate amount of intestinal contents. Sajou and others have pointed out that bacteria which normally inhabit the bowel become pathogenic with any marked increase or decrease of peristalsis. They speak of the colon bacillus under abnormal conditions developing the virulence of the typhoid bacillus. Under conditions of trauma, peritoneal infections or obstruction, bowel contents are retained, bacterial activity takes place and a high degree of toxicity is produced. Gases are created to an excessive degree and absorption and escape is retarded, and the bowel thus becomes distended; and the distension, as well as the inflammation, interferes with the circulation. Under conditions of ileus then, added to the underlying cause and the damage that it may do to the bowel, we find above the obstruction a more or less highly distended intestine with degeneration of the bowel wall and filled with highly toxic contents which cause toxemia even when such contents remain in the impaired portion of the bowel, but which more rapidly affects the patient if the removal of the bowel obstruction allows the infected contents to pour into the healthy portion of the bowel below the obstruction with its absorptive powers unimpaired.

After operation we may have a mechanical bowel obstruction uncomplicated by any infection except that of an intra-intestinal source, or we may have a peritoneal infection with paralytic ileus with the obstruction, if at all, entirely secondary to this; but we may have the two con-

ditions so closely accompanying one another, the peritoneal infection causing plastic adhesions, and these obstructing the bowel, the bowel obstruction causing distension and further bacterial development and invasion, etc., that it is difficult to say which is primary. It is plain then, that in all cases of ileus we have two conditions to combat: *first, the condition which caused the ileus and next the crippled bowel and toxic contents above the obstruction.*

The removal of such bowel contents and the establishment of a ready exit above the damaged area, providing the normal patency cannot be established by a procedure consistent with the life of the patient, is important. This not only relieves the patient of the fatal bowel contents, but turns this portion of the alimentary tract above the point of obstruction into a food-absorbing area, until such time as the patient's condition will warrant a safe removal of the obstruction.

We have found in some cases that the obstruction is easily removed, but that the bowel contents with the distention was a menace, and therefore an enterotomy with removal of bowel contents was carried out, with closure afterward. In other cases the obstruction was overcome by separating plastic adhesions, yet we lacked confidence in the affected area and enterostomy was decided on as a temporary procedure. In one case enterostomy was performed twenty-four hours after an enterotomy. In one recent case an ileostomy followed twenty-four hours after a cecostomy. In one case previously reported, repeated enterotomy was performed with happy results, although I would now be inclined to choose enterostomy. Any one who has seen the ready relief of the enterotomy of the herdsman or veterinary surgeon will readily appreciate the value of thus allowing the distended bowel to collapse in the human, aside from the fact that it becomes a procedure of necessity at times in order to return the bowels to the abdomen. If the patency of the bowel is not restored, or if doubt is entertained as to the permanency of function of the lower bowel, the safety furnished by an enterostomy will well warrant the inconvenience of a fecal fistula which may be counted on to close if the bowel becomes patent. It is not necessary to point out the need for operation in cases of bowel obstruction, but any effort that can be made to bring these cases to earlier operation is timely; fewer cases would need resection, and those needing it would be in better condition for it. The patient should learn the lesson that

it is the condition and not the early operation that is dangerous or fatal.

The next point I wish to make has not been uniformly adopted, and that is that in late cases a quick enterostomy should take the place of any prolonged effort to relieve the obstruction, and that enterotomy or enterostomy should accompany the operation for freeing the bowel if the bowel is left in doubtful condition.

Another point which has received altogether too little attention is that some degree of mechanical interference accompanies most peritoneal infections, and this with the paralytic ileus causes the bowel contents to be retained, which, undergoing pathogenic changes, furnish no small amount of the toxic agents which overwhelm the patient. Nearly every peritoneal infection arising from the lower abdomen throws the lower part of the alimentary tract out of use, while above this is retained toxic substance in a portion of the bowel that would functionate if any opening were provided, but which, if allowed to remain, aid in bringing about a fatal issue. Great relief would result from the escape of the gas, feces and toxins, and the collapse of the bowels. We must not lose sight of the value of stomach lavage at this time, but, should the relief be temporary or inadequate, it should be followed by enterostomy. Oftentimes a peritoneal infection which appears grave assumes comparative insignificance and is under complete control with intra-intestinal element of danger removed. It seems apparent then, *that few, if any, cases of peritoneal infection should proceed to a fatal issue without an effort having been made at the proper time to furnish an exit for the dangerous intestinal contents.* Instead of a tedious and possibly fatal delay to make a differential diagnosis between mechanical obstruction and peritoneal infection let us remember that either is greatly complicated by retention, and little hope may be entertained for the recovery of the patient unless this retention can be relieved. Peritoneal infections should be treated by peritoneal and intestinal drainage if milder measures fail. Obstruction should be removed and enterotomy furnish relief for an over-distended bowel, or enterostomy should furnish a means of escape if the obstruction remains or the relief is uncertain, and usually enterostomy should replace efforts to remove the obstruction in delayed cases or weak patients.

Technic.—I shall not go into great detail as to the technic. Enterotomy has been the operation of choice for the removal of foreign bodies, the removal of distending gases and liquid or solid

contents when the bowel was left unimpaired and by some is used for intra-intestinal medication. Enterostomy is used when temporary or permanent drainage is desired. Patients requiring these operations in acute conditions are usually not good subjects for operation, and freedom from the harmful effects of anesthesia is desirable. This may vary somewhat according to individual cases and different surroundings. We have sometimes used no anesthesia, at other times local anesthesia, either freezing or infiltration, has been used. At other times gas anesthesia has been employed and is quite satisfactory. Cases may present in which ether anesthesia may be justifiable, but it has not yet been necessary in my work unless the obstruction was to be removed. If the patient's condition is not good no extensive manipulation should be anticipated. The loop of the bowel above the obstruction as evidenced by great distention, and as low as is consistent with certainty of action, should be drawn out of the small opening, the loop is protected and an incision made or a trocar inserted, a glass tube or rubber rectal tube is usually inserted. After moderate efforts to remove bowel contents a purse-string suture may encircle the rubber tube, making a tight closure, the bowel is then attached to the peritoneum or fascia at the incision. Stitches to close the abdominal wound are of little value as they soon cut out, and for this reason I think it usually best to make a new abdominal opening for attachment of the bowel if the primary incision was made large for exploration. The rubber tube may be connected up with a bottle or be placed in a pus basin and thus the dressing may remain clean for several days. If, however, good bowel results are not obtained the tube may be removed, allowing the bowel contents a more direct exit. If this opening fails to give results, another effort should be made at some higher portion of the intestine.

Stewart recommends the use of the Murphy button to attach the bowel to a rubber tube, and Levison describes a complicated use of rubber dam, but I have found a purse string around a rubber tube to work neatly and protect the wound and dressing several days. When the bowel is in good condition, a small Murphy button attaching the bowel to a good-sized piece of rubber dam furnishes a good means of protection. Simplicity and quickness are important, however, and no great time should be lost. The bowel may be caught up to the wound with suture and the contents allowed to pour out. The wound and skin may be protected by the use of compound

tincture of benzoin, zinc oxid ointment or Lassar's paste. At times a periodicity of evacuation may be established which is a great aid in keeping the parts clean.

It seems that the higher the incision the more irritating the excretion. If the opening is too high the patient will suffer from inanition. J. W. Elliot collected the ejected fluid from the proximal portion of the bowel and injected it into the distal portion in a case of high enterostomy. Others recommend the injection of easily-digested or predigested food.

The Prognosis.—A carefully performed enterostomy is very little tax on a patient's strength and gives such relief as to decidedly aid the patient's chances for immediate recovery. If the obstruction is allowed to remain, as is frequently advisable, the fecal fistula will continue, but in most cases the fistula has closed if the bowel contents were free to travel the normal route. Great caution should be exercised in not yielding to the patient's entreaties to have the secondary operation for closure undertaken too soon, as the patient will get in better condition for operation as time goes on, providing the fistula is not too high, and many cases will close spontaneously. No definite rules can be laid down as to what the secondary operation should be. In one case it should be a resection with end to end or side to side anastomosis, and in another it might be merely a closure of the fistulous opening, and in still another a side to side anastomosis eliminating the obstruction may be done.

In conclusion I would say that every effort should be made to bring patients with bowel complication to earlier operation.

In cases of obstruction which can be relieved, but in which great distention has taken place, enterotomy may be chosen and the harmful contents removed.

In cases of obstruction not able to safely stand resection, and in cases of paralytic ileus, a quick enterostomy should be performed.

In cases in which pathology in the lower portion of the tract is aggravated by bowel contents as in colitis, sigmoiditis, diverticulitis, typhoid enteritis (Escher), etc., much relief may be obtained by diverting the flow through a temporary enterostomy.

Cases of peritoneal infection are frequently complicated by complete or partial obstruction as well as by paralysis. Enterostomy may be reasonably expected to improve either condition.

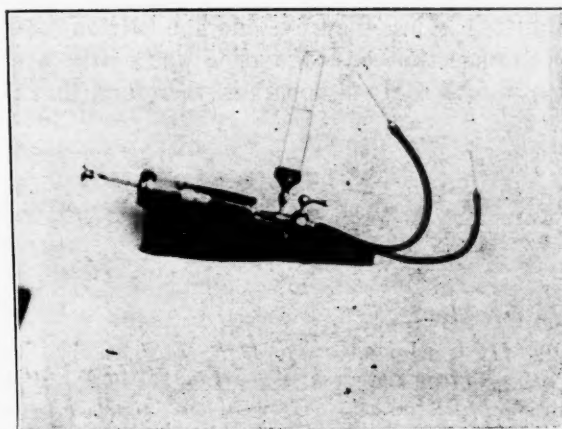
A METHOD FOR THE TRANSFUSION OF FRESH NORMAL BLOOD

HUGO A. FREUND, M.D.

DETROIT

During the past few years the indications for transfusing fresh blood from a donor to patient have been steadily increasing. That this procedure has now in innumerable instances saved, and at other times prolonged life, cannot be questioned. Without entering into the explanations for these phenomena, it has become universal experience that hemorrhages of some forms, as for example, in the melena neonatorum, are checked by the addition of a small quantity of blood to the recipient circulation.

We are indebted to Ginsburg, Crile and others for perfecting the surgical technic of direct transfusion of blood. There have been many modifications of the method suggested by these investigators. Even now the technic has in no way



Photographic Appearance.

been simplified. The methods are successful only in the hands of the most dexterous operators, and even then failures are frequent. Bernheim¹ has recently brought out this fact clearly, and the discussion that followed his paper at the meeting of the American Medical Association at Minneapolis emphasized, among others, two very important facts. First, that only those skilled in the procedure should attempt it. Second, that it is even then at times unsuccessful.

The indication for transfusion is sometimes emergency, and at other times necessary in surroundings where neither the instrument nor the technic of the surgeon are available. Therefore, it has seemed desirable that a method be devised, simple, yet adequate, that would permit anyone to properly perform this procedure. Kimpton

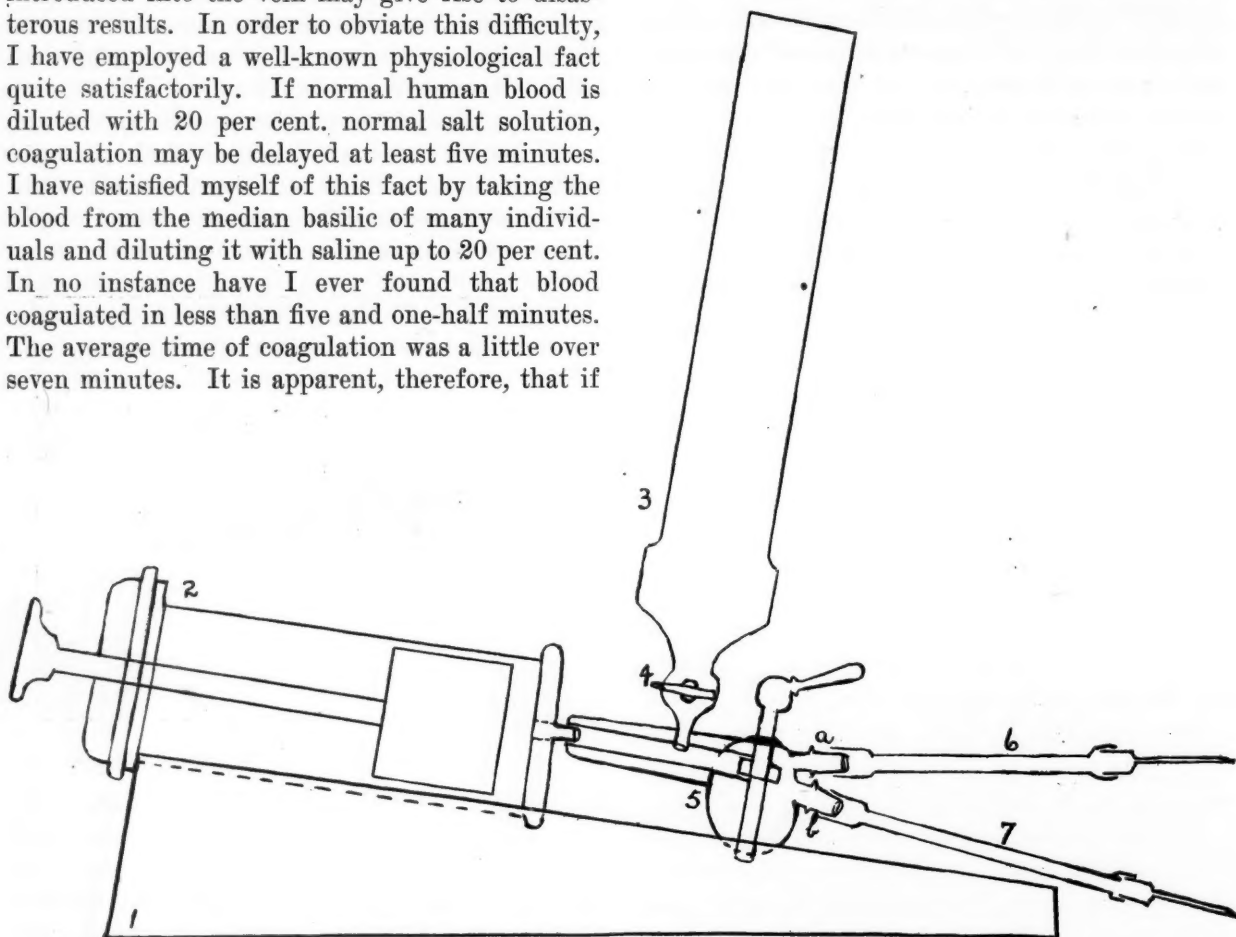
1. Bernheim: Jour. A. M. A., July 26, 1913, p. 268.

and Brown² have devised a tube composed of a glass cylinder with a specially curved canula, and a method whereby suction or pressure may be applied when desired to withdraw or inject blood. This tube is lined with 50 degrees, Centigrade, paraffin. It needs special preparation for sterilization. The method has evidently met with success in a number of hands.

The great drawback in every method of this kind which brings the blood into contact with any foreign substance is the rapid formation of fibrin which soon plugs the needle or tube, and if introduced into the vein may give rise to disastrous results. In order to obviate this difficulty, I have employed a well-known physiological fact quite satisfactorily. If normal human blood is diluted with 20 per cent. normal salt solution, coagulation may be delayed at least five minutes. I have satisfied myself of this fact by taking the blood from the median basilic of many individuals and diluting it with saline up to 20 per cent. In no instance have I ever found that blood coagulated in less than five and one-half minutes. The average time of coagulation was a little over seven minutes. It is apparent, therefore, that if

AUTHOR'S METHOD

Meeting as one does so frequently in internal medical practice indications for transfusion, I devised a method and have employed it with satisfactory results for about six months. Dr. J. Walter Vaughan of this city, to whom I showed this method and instrument, has urged me to report it. He mentioned its usefulness in the discussion of Dr. Bernheim's paper before the Surgical Section at the American Medical Association meeting of 1913. Since that time numerous requests for this instrument and for a descrip-



1. Wooden inclined base. 2. Twenty-cubic-centimeter syringe. 3. Glass cylinder for normal saline solution. 4. Stop-cock. 5. Two-way irrigator with stop-cock and attachment to syringe. 6. Shorter tube with larger needle leading from donor. 7. Longer tube with smaller needle leading to recipient.

blood be withdrawn under aseptic precautions, diluted 20 per cent. with normal saline solution, and immediately injected again into the vein of a recipient, all indications for transfusion are fulfilled without introducing any foreign or dangerous substance into the circulation or modifying the constituents of the normal blood. This may be readily done without the need of surgical procedures or use of a paraffined tube.

tion of it have come to both of us. I therefore wish to take this opportunity of describing the instrument and of the technic ready for its use.

The original instrument consists of a well-fitting aspirating syringe, holding 20 c.c., a "two-way" stop-cock irrigator with a glass cylinder attached to this device, and two tubes with needles attached leading from each tube. The glass cylinder is fitted also with a small stop-cock. The whole is mounted on an inclined wooden base, which rests on the table. See diagrams.

² Kilmington and Brown: Jour. A. M. A., July 12, 1913, p. 117.

METHOD OF PROCEDURE

Into the glass cylinder is poured normal physiological salt solution a little above body temperature. By opening the stop-cock of the cylinder and drawing out the plunger of the syringe, normal salt solution is taken into the syringe to about 5 c.c. The stop-cock is then closed. Both needles are then held vertically (as seen in the photograph), and normal saline washed through them until all air is removed from the rubber tubing and the needles. Four c.c. of normal salt solution still remains in the syringe. The larger needle is then inserted into the median basilic of the donor and fastened there with adhesive. The lever of the stop-cock is turned, permitting of suction to be made from the donor. This shuts off the saline that remains in the tube going to the recipient. Immediately suction is made on the tube in the vein of the recipient and the blood flows into the syringe. From the average vein 16 c.c. may be drawn into the syringe in less than half a minute. The syringe is revolved so as to thoroughly mix the blood and the saline. As soon as the syringe is filled, a little of the mixture of the blood and saline is injected back into the donor, so as not to leave fresh blood without admixture of saline in the tube. The lever of the stop-cock is then turned toward the recipient, who first receives the saline remaining in the tube and then receives the entire injection of blood. At this point, for safety, if the experiment has not proceeded within the space of three minutes, it is well to wash both the donor's and the recipient's needles and tubes with a little saline solution, which may be obtained by opening the stop-cock from the cylinder and drawing salt solution into the syringe again. This may be done again and again until as much blood is injected as desired.

PERSONAL EXPERIENCES

I have employed this procedure successfully in seven cases up to the present time. From one individual, a polycythemic patient, I took blood, 160 c.c. in all, and injected into a pernicious anemic. Recently, blood was taken from the jugular vein of a normal rabbit and reinjected into one of the veins of the ear. In all, but 20 c.c. was taken. The purpose was to observe if any change occurred either in the heart or lung from the experiment. The animal was killed at the end of twenty-four hours, and the pathologic examination of the heart and lungs by Dr. Morse and myself revealed no gross changes, such as might come from the injection of a small clot or particle into the lungs, giving rise to an infarct or pulmonary embolus.

I believe that this method is so simple, yet efficient, that its applicability will appeal to every general practitioner. The instrument is readily constructed, easily sterilized, offers very little chance for infection, supplies the desired blood in any quantity and in a fresh state, and may be readily manipulated with a little practice and little assistance.

355 Woodward Avenue.

SOME OBSERVATIONS ON ANESTHESIA *

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The purpose of this paper is to make some practical suggestions concerning the administration of anesthetics. We shall not attempt a formal discussion of any of the many questions that arise in connection with anesthesia. An effort will be made to report observations made during the administrations of a number of anesthetics. Such a paper will, of necessity, contain very little that is new and a great deal that has been said many times before. It is possible, however, that an occasional discussion of such a subject as this may be not without some benefit to us. The reiteration of old facts may serve to impress them better.

THE INDUCTION OF ANESTHESIA

The course of anesthesia often depends on a good start. The attitude of the patient toward taking the anesthetic has much to do with the way it starts. For this reason attention should be paid to the conditions present when the patient is brought into the room. If a sensitive, nervous patient comes into a room where the doctors or nurses are talking and laughing, the effect on the patient may be bad. Loud talking, discussing of operations, joking and story-telling often do not make a good impression on the patient.

The anesthetist who can quickly win the confidence of the patient has a big advantage. The patient is naturally apprehensive about the anesthetic. Frequently, the anesthetist is a total stranger to the patient. The patient knows that the surgeon has confidence in his ability to properly administer an anesthetic, but may know nothing else about him. A careful, not too hurried, examination of the chest, the mouth and the general condition gives the patient the impres-

* Read before the Kalamazoo Academy of Medicine, May, 1913.

sion that a real effort is being made to properly care for him. The patient almost always is made more comfortable and tranquil by being assured that conditions are favorable and that he will be able to take the anesthetic all right. Where a patient is very ill, an especial effort should be made to encourage and reassure him.

From the standpoint of the patient the beginning of anesthesia is the difficult part. It is the only part of which he has any knowledge or memory, and it is from this part that he will get his impressions of what it is to take an anesthetic. For this reason it is very desirable that the first stage of anesthesia should be made as little unpleasant as possible and that as little struggling and resisting as possible should occur. If without any particular directions to the patient, an ether-cone well charged with ether is put down over the patient's face, he is in trouble at once. He does not know what to expect, he is unable to breathe and feels that some terrible mistake is being made. He begins to cough and struggle; the anesthetic is badly started and the patient will always have a horror of taking any subsequent anesthetic. On the other hand, if the patient is told what to expect, if the ether is begun slowly and the patient told what to do, things start off better. If from time to time, the patient is assured that all is going well, he will be likely to get along better. It has been my observation that if a patient is told to blow out and to try to get the ether all out, he is much more willing to attempt it than when he is told to take deep breaths. Many patients seem to have a fear that the surgeon will begin his work before consciousness is gone. It is often advisable to let the patient know that he is not yet anesthetized fully and to assure him that nothing will be done until consciousness is gone. Coughing and choking during the first stages of ether anesthesia are, as a rule, due to the ether being given in too highly concentrated form. Often removing the cone and allowing air will be sufficient to establish regular breathing. From five to fifteen minutes are usually required to produce surgical anesthesia, depending to a great extent, on the state of mind of the patient. I am quite convinced that it is a mistake to try to hurry the first stages. Possibly in young and frightened children it may sometimes be best to smother them under, but the more I try, the more I believe in trying to take time with children as well as adults.

DUTIES OF THE ANESTHETIST

A few suggestions may be made as to the care of the patient while under anesthesia. Because a patient is unconscious is no reason why every effort should not be made to do those things which would make the patient comfortable were he awake. In emergency work, patients are especially likely to be neglected in this respect. I have seen patients anesthetized with heavy shoes on their feet with which they could do much damage to themselves. In women, hair pins are frequently a source of danger to the scalp. False teeth and other foreign bodies in the mouth are a menace. Large corpulent patients appreciate a comfortable pillow under the head to bring the head up in a normal position. Most patients are better off with some sort of a pillow under the head. In every case it is the business of the anesthetist to make sure that the arms of the patient do not hang over the table. Such a position may result in a troublesome paralysis. Rough handling of the patient in any way is not desirable. Constant pressure over the angles of the jaw for a prolonged operation may cause the patient much discomfort afterward. Unnecessary injury to the tongue or to the cornea is likely to cause trouble later. Awkward or unnatural position of the patient on the table should not be maintained any longer than necessary for the operative work. A prolonged Trendelenburg position is bad for the patient.

The purpose of anesthesia is to render the patient insensible to pain and to relax the muscles. When these objects have been attained, anesthesia is deep enough. Profound anesthesia is not only dangerous for the time being, but makes the patient more toxic afterward. The anesthetic should be as light as is compatible with rapid work and proper exposure. Vomiting is an accident, and the anesthetic should be deep enough to prevent this. In abdominal operations it is often observed that more anesthetic is required while the parietal peritoneum is being handled. When this has been opened and packed off, lighter anesthesia can be had without any trouble. The sooner the patient awakens after the operation the better it is for the patient. Anesthesia may often be timed so that signs of returning consciousness begin to appear as the last stitches are being introduced. It requires more attention and more exercise of judgment to maintain anesthesia of this sort than it does to keep the patient profoundly anesthetized with reflexes all gone, and with stertorous slow breathing. But later the patient must suffer on account of this profound intoxication. Postoperative

vomiting, bronchitis, pneumonia, albuminuria and the various other evidences of intoxication must bear a direct relation to both the depth and duration of anesthesia.

ANESTHESIA IN NOSE AND THROAT OPERATIONS

In operations on the throat and mouth, this factor is very important. If anesthesia is so deep that all reflexes are lost, the danger of postoperative complications from aspiration of blood and mucus are great. A profound anesthesia may facilitate operative work, but it is a source of danger to the patient. The administration of vaporized ether through a tube aids very greatly in obtaining a continuous light anesthesia in work about the mouth and throat. Anesthesia may be kept up while the operator is working and it is unnecessary to stop the operator from time to time on account of returning consciousness. This arrangement also makes the accident of vomiting during such operations much less likely to occur.

THE CHOICE OF ANESTHETIC

The discussion of the choice of anesthetic will not be entered into. Chloroform is probably much less safe than ether, and should not be given unless there are definite indications for it. Chloroform is often chosen for operations on children and for obstetric operations, without any special reason. In my experience, chloroform is as dangerous in such cases as in any other class, and should not be used as a routine procedure. The dangers of sudden death and post-anesthetic complications are as great in these cases as in any other. For obstetric anesthesia to control pain, nothing can take the place of chloroform, but when any obstetric operation is necessary and complete anesthesia is desired, ether is the more desirable anesthetic.

The claim is made that chloroform is pleasanter to take and is not so irritating to the respiratory passages. For some time we have been giving ether vapor passed through hot water by the method suggested by Gwathmey. Two ordinary bottles are used. In one hot water is placed and in the other ether. Air is forced through the ether and this air mixed with ether then passes through the hot water. Ether given in this way and started slowly is not any more unpleasant or irritating than chloroform, and may be given in cases of infections of the respiratory passages as safely as chloroform. A great deal of work has been done to test the effect of warming ether vapor, and most experimental workers come to the conclusion that ether vapor

is not really any warmer after such procedures than when given by the open method. I am not in a position to question the accuracy of these experiments, but I am sure that patients suffer less irritation of the respiratory mucosa after passing the ether vapor through hot water. Theoretically, there is no reason why ether vapor should not be warmer after passing through hot water than when volatilized on the cone in close proximity to the patient's face. An argument in favor of the Gwathmey method is that the vapor is all washed and freed from any impurities that may be taken up by the water. Whether it is on account of the warming or the washing the vapor is less irritating.

NITROUS OXID AND OXYGEN ANESTHESIA

It may be of value to relate the result of our experience with nitrous oxid and oxygen for general anesthesia. Crile advises the use of preliminary medication with morphine and hyoscine or atropine where this anesthesia is to be used for any prolonged period. Patients relax better and take much less nitrous oxid. Patients do very much better with gas and oxygen with preliminary medication than without it.

The advantage of gas and oxygen are that it is pleasant, anesthesia is quickly produced, the patient is conscious as soon as the anesthetic is stopped and there are apparently no toxic after-effects. In the hands of one accustomed to its use it is as safe or safer than ether. Its disadvantages are first that it is expensive, and second, that it does not always produce complete relaxation. When the preliminary hypodermic is given relaxation is almost as perfect as with ether. There is sometimes a little struggling in going through the peritoneum and in walling off, but after this the anesthesia is often as even or more so than with ether.

A great many machines are made for the administration of gas and oxygen. The principal requirements for such a machine have been described as follows: First, an even, constant flow of the two gases without variation in pressure. Second, a single easily regulated valve for accurately controlling the mixture. Third, a simple reheating apparatus. Fourth, a face piece that makes an air-tight approximation to the face. Dental anesthetics sometimes fail, because this last requirement is not met with. An effort is made to anesthetize the patient with a mouth gag over the cheeks. The patient gets enough air around the gag to prevent sound anesthesia. A cork or rubber gag does not interfere with the administration of the gas.

Dentists are now using nitrous oxid to produce partial anesthesia or analgesia when preparing cavities. In some cases this gives excellent results, and when given with proper care, would seem to be entirely safe.

CONCLUSIONS

To sum up the things that we wish to emphasize in this paper:

1. Great care should be taken to induce anesthesia without excitement or struggling.
2. Patients under anesthesia should not be allowed to suffer any injury or be kept in awkward positions unnecessarily.
3. Anesthesia should be as light as is compatible with rapid work and good exposure.
4. Obstetric operations and operations on children are not *per se* indications for chloroform.
5. Ether vapor that has been warmed and washed is less irritating to the respiratory mucosa.
6. Gas and oxygen make the pleasantest and least toxic anesthesia.

THE USE OF PITUITRIN IN OBSTETRICS

WITH REPORT OF SIXTY-ONE CASES

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DETROIT

It is the object of this paper to report my observations on the action of pituitrin in labor. I have used the extract of the posterior lobe of the pituitary gland in forty-nine private cases, and twelve hospital cases of women in labor at or near term. I have also used it in seven cases of unavoidable abortions, which were incomplete. As the hospital cases were under my observation during only a fraction of their labor periods, I will confine my remarks to the private cases, most of which were under my care from the commencement of labor.

PHYSIOLOGICAL ACTION

The hypophysis cerebri of pituitary gland is located in the sella turcica, a depression in the superior portion of the sphenoid bone. It is formed from an ectodermic pouch from the buccopharyngeal cavity which partly envelops a prolongation from the base of the anterior cerebral vesicle.¹ The pouch forms the pars anterior, the other the posterior lobe. The pars anterior is of importance because of its influence on growth and nutrition—particularly carbohydrates.

1. Minot's Embryology.

The extract from the posterior lobe acts as a powerful galactagogue.² It causes a long-continued rise of blood-pressure, due to the augmentation of the force of heart beat and peripheral vascular constriction.³ Renal arteries dilate and marked diuresis, due to the stimulation of renal epithelium, occurs.⁴ It stimulates both intestinal secretion and peristalsis. It is essential to carbohydrate metabolism, and injections of it produce glycogenolysis, and continued use causes excessive emaciation.⁵

Of prime importance is the effect of the posterior lobe extract on the pregnant uterus at or near term. Erdheim and Stumme⁶ have shown that the color changes from a grayish red to white during pregnancy. There is a considerable increase in weight of gland of a primipara over a nullipara. That of a multipara weighs almost double that of a nullipara. The size increases correspondingly. During pregnancy there is a gradually increasing physiological activity until the termination of labor. After parturition there is an involution which is complete at the termination of the lactation period.

Considerable work has been done experimentally to demonstrate the action of hypophyseal extract on uteri of dogs, rabbits and guinea-pigs. The non-pregnant uterus responds by intermittent contractions after the injection into the body of moderate doses. That of the virgin reacts less strongly than that which has borne its young.⁷ There is a slight increase of muscle tonus, and the contractions are weak.

There is a slight increase in the response of the uterus in early pregnancy over that of a non-pregnant uterus. Abortion may be produced by very large doses on lower animals, and when started before the injection the process is hastened by the extract. As pregnancy advances there is an increased susceptibility of the uterus to the action of pituitrin. The nearer term the stronger the contractions produced.

The maximum effect is seen during labor at term. The uterus is least sensitive at the beginning of the first stage of labor; the sensibility gradually increases from that time until the end of the second stage when the response is greatest. The maximum effect continues through the driving out period. The tonus is greatest; contractions come oftener, are stronger and of longer

2. Ott: Proc. Soc. Exper. Biol. and Med., 1911, viii, 41.

3. Oliver and Schafer: Jour. Physiol., 1895, xviii.

4. Schafer and Herring: Phil. Tr. Roy. Soc., London, 1906, cxlix.

5. Cushing: Pituitary Body.

6. Erdheim and Stumme: Beitr. z. path. Anat. u. z. allg. Path., 1909, xlv.

7. Herman Fuhner: Deutsch. med. Wchnschr., 1913, No. 11.

duration after the use of the extract. The third stage shows less reaction than the previous one.

During lactation the effect is marked, but less so than during labor, but both tonus and contractions are increased. "The susceptibility of the uterus to pituitrin stimulation decreases as the period of lactation advances."⁸ At the end of this stage the sensitiveness equals that of the non-pregnant uterus.

Pituitrin in ampoules containing 1 c.c. solution of 2 gm. of posterior portion of the gland, and pituitary extract in vapofoles containing 5 c.c. solution of 1 gm. of the gland were used. This was injected intramuscularly and caused little pain and no other local reaction. No toxic or deleterious symptoms were noted. Fresh preparations were used from the sealed tube so that there was no chance of contamination or deterioration. In cases the dose was repeated several times. It is my belief that the minimal effective dose on the average uterus is 0.2 gm. of the gland.

The effect on the human uterus is apparently the same as that produced on the lower animals. The non-pregnant uterus does not seem to react to the extract, though the slight effect produced may not be sufficient to be noted. It is not possible to induce labor in the pregnant woman by the use of ordinary doses. After labor has begun the effect is very slight at the beginning of the first stage. As the cervix thins out and the external os dilates the response to pituitrin increases. As the dilatation of the os externum becomes complete, the maximum result is noted. This continues until the expulsion of the fetus. The uterus continues through the third stage less affected than during the previous one. The effect on the uterus is to increase the muscle tonus. The effect on the contractions is to increase their frequency, lessen the time between them, strengthen and lengthen their duration. The uterus does not become tonically contracted as from ergot.

CASES AND AUTHOR'S EXPERIENCES

I have collected 49 cases from my private practice in which pituitrin was given to hasten the termination of labor which had begun. Of these, 31 were primiparae, 18 multiparae. All were measured and only one, No. 24, had a contraction of any importance. In no case was there any contra-indication for its use. The average time from the injection to the end of the second stage in primiparae was 3.8 hours. The average time of complete labor was 17.1 hours. The average

time from the injection of pituitrin among multiparae until the end of the second stage was 3.17 hours, and the average time for the complete act was 9.8 hours. The majority responded to 1 c.c. pituitrin. Except in the cases noted, the response was very evident in the longer duration of contractions, shorter interval between them and greater strength. This was noted by the patient herself at the end of 5 to 10 minutes after injection. In two there seemed to be a tonic contraction at first with severer clonic contractions added at regular intervals. Case 43 was one which had a tonic contraction for almost one-half hour.

One objection to the use of pituitrin is the uncertainty of its action. A few women do not seem to respond at all or but slightly to it. Cases 47 and 48 illustrate this forcibly; No. 47 had a precipitate delivery after the injection, whereas she had been delivered of her other children after forty and thirty-two hours by forceps; No. 48 did not react to 4 c.c. from two different extracts, and the inertia was not overcome in the least. This labor was thirty-six hours and her first was only eighteen hours without the use of pituitrin. Cases 2, 10 and 20 show the same ineffectiveness. It is my belief that these uteri do not react, because there has been a deficiency of birth substances transported from the fetus.⁹ These serve to activate the uterus and act as hormones for the secretion of pituitrin. A deficiency may deter the activity of the extract.

No doubt the inefficiency of the drug has at times been due to the age of the extract or a deteriorated product. This is evident in Case 10, where 4 c.c. had been given without any evident result. A 5th c.c. of an absolutely new product was very effective.

There is an individual variability in uterine activity and sensibility. Normally, there is a sufficient secretion of pituitary extract during labor to aid completion of the act. When there is a deficiency of this, and otherwise the individual is normal, the act is completed rapidly when the necessary quantity is supplied. It may be that the small doses act as adjuvants to aid the maternal secretion. The necessity for varied dosage probably depends largely on the amount of maternal extract present.

In this connection it is important to distinguish true inertia from exhaustion. Like other muscular tissues the uterus loses its tone, strength and contractile power after long-continued contractions. It finally acquires a state of exhaustion in which it is not even sensitive to

8. Lescotier and Closson: Jour. Michigan State Med. Soc., October, 1912.

9. Welz: Am. Jour. Obst., July, 1913.

stimuli, or only weakly so. At such a time rest will permit it to regain its former strength or nearly so. Then it will react to stimuli as it did before the state of exhaustion. In a practical way we should give an anodyne instead of a stimulant in this condition and permit the uterus to regain its strength before working again.

Case 2 illustrates this well. A primipara of 30 years had ruptured membranes hours before labor began. As the pelvis was normal and labor proceeded normally, though slowly, she was given morphia the first two nights. The failure of 3 c.c. of pituitrin to end labor on the third day was due to uterine exhaustion. Easy low forceps delivery was indicated, because of weak fetal heart and discolored amniotic fluid.

It is claimed that there is a greater liability to deep cervical lacerations. It is noteworthy that some whose dilatation was most rapid had no sign of any cervical laceration (Case 33). None of this series suffered from a cervical laceration sufficient to require immediate suture. There is an increased liability to laceration resulting from the rapid dilatation of a very rigid cervix. These uteri do not usually dilate very rapidly even after some stimulation. Those which are quite elastic seem to be able to dilate rapidly without injury to their integrity.

As these were all private cases I had opportunity to watch them carefully for signs of threatened uterine rupture. There were none of the ordinary signs of this condition such as tense round ligaments, thinning out of lower uterine segment, pain or tenderness along the lower lateral uterine walls. All pelvises had been measured and examined previously to ascertain that there was no contraction or obstruction. There is a possibility of such an occurrence where there is a disproportion between the size of the fetus and the pelvis. It might occur from an obstruction or even because of a very rigid cervix, where the pituitrin causes excessively severe contractions. The possibility is remote, but should be kept in mind in order to be forehanded.

None of this series showed a sign of premature separation of the placenta as a result of the severe contractions. There is a possibility of this accident occurring after the exhibition of pituitrin, though I do not believe more so than in labor without it. The third stage resembles the ordinary third stage, the placenta taking about as long to become freed as in other cases. This indicates that the more violent contractions do not tend to loosen the placenta until the usual time after the fetus is expelled as in cases where

no pituitrin is used. The amount of hemorrhage was about the same as in ordinary cases.

There was slight asphyxia in Cases 2 and 20. This I consider due to the prolonged labors and not to the use of pituitrin. Neither uteri was stimulated by the use of the extract. The fetuses were in bad condition from prolonged cerebral pressure, because of weak contractions. There was no death from asphyxia or even deep asphyxia. It is more dangerous to permit a condition of inertia to persist for a long period than to aid the expulsion in a natural way. The prolonged pressure is much more harmful to fetal head and maternal soft parts than the extract could be.

This extract has been recommended to control post-partum hemorrhage. This is not a rational procedure, because a tonic contraction is desired, and pituitrin causes intermittent contractions. Ergot cannot be displaced for its post-partum effect, because it produces the desired tonic contraction of the uterus. Pituitrin might be used as an adjuvant to ergot on account of its power to increase the muscle tonus of the uterus.

In seven cases of abortion or miscarriage pituitrin has been found to be of little service. In mid-term pregnancies where abortion is inevitable it will aid in the dilatation of the cervix and the expulsion of the products of conception. The drug has little effect on the uterus of early pregnancy, and none whatever in removing placental particles which remain attached to the uterine wall after the fetus has been expelled. Only mechanical separation can do this and then ergot is still the reliable drug to rely on for a continued contraction. Placenta and membranes which remain adherent to the uterus in premature labor cannot be removed by pituitrin either.

In the case (No. 24) of cesarotomy, 1 c.c. of pituitrin was given just before the operation to aid the action of ergot given at the same time by increasing the uterine muscle tonus.

CONCLUSIONS

Pituitrin is a powerful drug and care should be used in its administration. It should never be used until the accoucheur is familiar with his case and certain that no harm will result from its use. It is absolutely contra-indicated where there is a disproportion between the size of the fetus and that of the pelvis, or where there is an obstruction. Instead of pituitrin, rest is indicated where the uterus is exhausted. As the drug acts best toward the termination of labor, and only slightly at the beginning, the time to use it is when dilatation of the cervix is complete or

nearly so. Then the man in a hurry may use it instead of applying forceps as is too frequently done. The intelligent use of this extract at the proper time should displace the forceps very frequently. The result should be lower mortality and less morbidity among the new-born and mothers. It should lessen the suffering of

mothers in numerous cases. Only when it is a rational procedure should it be used; it is senseless to inject it in every case. After the injection has been given, the physician should never leave his patient until labor is complete, for fear of precipitate labor; also, the case should be watched for possible trouble.

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CASES IN WHICH PITUITRIN WAS USED

PRIMIPARAE

Name	No.	Date	Dilatation of os ext.	Time from inj. to end* Hours	Hours in labor†	Remarks
Mrs. C. S.	1	Feb. 23, '13	Complete	1/3	5 1/2	
Mrs. F. N.	2	Feb. 6, '13	2 cm.	26	75	Pelvis normal, age 30 years, parts inelastic.
Mrs. C. K.	3	Feb. 2, '13	8 cm.	1 1/2	5 1/2	
Mrs. M. P.	4	Jan. 31, '13	8 cm.	1 1/6	7 1/2	
Mrs. C. P.	5	Feb. 6, '13	5 cm.	1 1/4	9	Breech extraction.
Mrs. K. H.	6	Feb. 21, '13	6 cm.	2	7	
Mrs. M. H.	7	Feb. 21, '13	Complete	1 1/6	5	
Mrs. J. W.	8	Jan. 24, '13	6 cm.	4 1/3	12	Primipara thirty-four years.
Mrs. E. B.	9	Jan. 18, '13	9 cm.	3	38	3 c.c. given.
Mrs. F. M.	10	Feb. 12, '13	1 cm.	10	13	5 c.c. given, soft parts tense.
Mrs. C. B.	11	Jan. 10, '13	7 cm.	2 1/4	8	
S. S.	12	Jan. 27, '13	5 cm.	6	11	Dry labor.
Mrs. W. T.	13	Nov. 20, '12	5 cm.	6	13	
Mrs. J. S.	14	Aug. 7, '12	4 cm.	5 1/2	10	
Mrs. A. H.	15	July 10, '12	7 cm.	2	9	
Mrs. K. M.	16	April 27, '12	3 cm.	3 1/2	12	
Mrs. S.	17	Oct. 11, '12	4 cm.	2 1/2	11	
Mrs. B.	18	Nov. 1, '12	8 cm.	1	21	Forceps. Weak fetal heart.
Mrs. C. S.	19	March 25, '13	8 cm.	3	48	
E. L.	20	March 31, '13	3 cm.	12	35	Forceps for weak fetal heart, 3 c.c. pituitrin.
Mrs. R. H.	21	April 6, '13	4 cm.	3	26	
Mrs. F. A.	22	April 17, '13	8 cm.	1 1/4	11 1/2	
Mrs. A. S.	23	April 25, '13	6 cm.	3/4	4 3/4	
Mrs. F. S.	24	May 3, '13	Complete	1/2	11	Cesareotomy, true diagonal di—8 cm. rachitic pelvis.
Mrs. A. B.	25	May 17, '13	6 cm.	6	11	
Mrs. F. H.	26	May 25, '13	5 cm.	1 1/2	6	Macerated, 7 1/2 months fetus; chronic nephritis.
Mrs. W. K.	27	June 18, '13	3 cm.	3	3	
Mrs. J. L.	28	June 24, '13	2 cm.	3 1/2	10	2 c.c.
Mrs. F. R.	29	July 19, '13	6 cm.	2	26	Dry labor.
Mrs. C. S.	30	June 21, '13	7 cm.	1	22	Dry labor: breech extraction.
Mrs. A. V.	31	June 27, '13	5 cm.	1	25	Forceps for heat exhaustion.

* Average, 3.8 hours.

† Average 17.1 hours.

MULTIPARAE

Name	No.	Date of Confinement	No. Labor	Dilatation of os ext.	Time from inj. to end* Hours	Hours in labor†	Remarks
Mrs. J. A.	32	Feb. 17, '13	2	5 cm.	1 1/2	8	Twelve hours for first child.
Mrs. L. S.	33	Feb. 7, '13	2	1 cm.	1	2 1/2	Twenty-nine hours for first child.
Mrs. Wm. H.	34	Feb. 14, '12	3	7 cm.	1 1/6	3	Previous short labors.
Mrs. W.	35	Mar. 5, '12	3	6 cm.	1 1/2	6	Previous short labors.
Mrs. O. H.	36	Nov. 1, '12	3	7 cm.	1 1/2	4	
Mrs. P. R.	37	Dec. 29, '12	3	5 cm.	2	6	Previous labors easy.
Mrs. D.	38	Aug. 16, '12	2	4 cm.	2 1/2	7	
Mrs. C. M.	39	Dec. 9, '12	3	3 cm.	4	13	
Mrs. F. M.	40	June 19, '12	4	4 cm.	5	14	
Mrs. F.	41	July 15, '12	3	3 cm.	4 1/2	7	
Mrs. J. M.	42	July 22, '12	3	7 cm.	1/2	12	Premature 33-week child.
Mrs. E. W.	43	Jan. 19, '12	3	2 cm.	3/4	4	Previous labors, 48 and 24 hours.
Mrs. A. P.	44	Mar. 12, '13	2	7 cm.	1 1/4	4	
Mrs. J. B.	45	Mar. 31, '13	3	4 cm.	1 1/2	22	
Mrs. M. M.	46	May 19, '13	2	8 cm.	1	3	
Mrs. A. T.	47	July 8, '13	3	Complete dil.	1/4	12	Previously forceps after 40 and 32 hours.
Mrs. J. G.	48	July 9, '13	2	2 cm.	26	36	Dry labor, 4 c.c. pituitrin.
Mrs. E. C.	49	April 27, '13	2	6 cm.	1 1/4	13	

* Average 3.17 hours.

† Average 9.8 hours.

EMERGENCY ABDOMINAL SURGERY IN THE PRACTICE OF THE COUNTRY PRACTITIONER *

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STEPHENSON, MICH.

Appreciating very highly the honor which you have bestowed on me in having elected me President of the Upper Peninsula Medical Society, I have taken the liberty of addressing you on a subject which I feel is very close to all of you and at the same time altogether timely.

Above one of the entrance doors of one of the greatest institutes of physiology of international reputation are written the words, "Nobody enter this institute without perfect knowledge of higher mathematics." Similar to this I believe that every patient demanding abdominal surgery ought to have, in our days, a plate on his abdomen with the inscription, "Without perfect knowledge of all phases of abdominal surgery nobody enters this abdomen."

Taking it for granted that very few physicians in general practice can fulfil the above requirements of abdominal surgery, we must, on the other hand, take into consideration that the practitioner in country practice is called on very often to act promptly and energetically in cases which I would like to call cases of emergency abdominal surgery. Such as for instance, beginning general peritonitis from perforation of the appendix, perforation of a gastric or duodenal ulcer, perforation following typhoid fever, trauma (such as a kick by a horse or gunshot wound of abdomen), general peritonitis following septic abortion or confinement, incarcerated hernia, extra-uterine pregnancy, pregnancy with eclampsia, pregnancy connected with contracted pelvis, etc. All cases which, as you know, demand immediate surgery of the best kind. Some of these cases, as for instance, ruptured extra-uterine pregnancy, where there is free hemorrhage going on without the formation of a hematocele, are in such a deathly state of sickness that the idea of transporting the patient to a nearby hospital cannot be taken into consideration, and in other cases, such as beginning general peritonitis from perforation of the intestines, it cannot be denied that the transport to a hospital must necessarily spread the existing inflammation and thereby be a detriment to our patient. Some of these patients after a transport over a long country road, arrive in such a miserable state at the hospital; hastened by such transport the case is absolutely hope-

less. This is quite avoidable at the present time. There can now be found a surgeon within reachable distance of almost every place armed with modern equipment and prepared to do surgery anywhere. With the steady improvement of highways and the use of automobiles the radius of territory for surgical home attendance is widening. The time can never come when human beings ill with acute appendicitis and strangulated hernia or intestinal gun-shot wound can be shipped to city hospitals to better advantage than they can be cared for by reasonable skill and house conditions at home.

Having the above facts before us and for the purpose of doing justice to our patients, it has been my practice within the past ten years to have all those cases operated on in their private homes by an expert surgeon; the results achieved by this practice, which I would like to lay before you to-day, are not only equal to any hospital record, but I believe that many a patient's life has been saved, who, if he or she had been transported, would have succumbed. All cases of beginning peritonitis originating from acute appendicitis were operated on at the earliest possible moment. Whether it was twenty-four hours after the onset or seventy-two hours, three days or four days, did not play any figure whatsoever. In other words, the so-called Ochsner treatment has never existed for us, because no man can tell what course a beginning peritonitis will take if not operated on promptly. In all cases, wherever feasible, the appendix was removed and only in cases of abscess where its removal would have produced too much traumatic injury to the adjacent bowels, the abscess was drained and the removal of the appendix left for a subsequent operation, if such proved necessary.

AUTHOR'S CASES

There were forty-four pus patients operated on with only two deaths. One of the patients that died was seen the first day she was taken sick, and an operation advised which was refused; on the fourth day the parents requested an operation, which was performed, but she died the next day. The other patient that died was operated on the fifth day; both were cases of general peritonitis. There were three patients operated on during pregnancy; one at the third month, one at the fourth and one at the sixth month; pregnancy was uninterrupted. Among our cases was one of general peritonitis following septic abortion, with pulse 130, constant vomiting without effort and a case almost in *extremis*. After rapidly opening the abdomen the uterus and

* President's Annual Address, Upper Peninsula Medical Association Nineteenth Annual Meeting, Ishpeming, Aug. 6, 1913.

tubes covered with diphtheria-like membrane were wrapped in iodoform gauze, and the abdomen, filled with pus exudate, drained. The patient recovered.

There was an interesting case of ruptured extra-uterine pregnancy in the fourth month together with an intra-uterine pregnancy of the same month. The patient was operated on at two o'clock at night, the abdomen was found filled with blood and the extra-uterine pregnancy removed. The intra-uterine pregnancy aborted three weeks after the patient was able to be up and around.

In one case of ruptured extra-uterine pregnancy—in a very primitive farm-house where it was impossible to obtain a suitable Trendelenburg position by fastening a chair to a table (which we usually use in cases where such a position is required)—the husband was used for such purpose. By throwing the legs of his wife over his shoulders in such a manner that the pelvis was lying on his neck, an excellent Trendelenburg position was achieved.

There was one case of perforation from gastric ulcer followed by general peritonitis, and one perforation of duodenal ulcer with beginning peritonitis. The first one, a girl 19 years of age, operated on four days after perforation, but the peritonitis had already gained such headway that she died five days after the operation. The perforated duodenal ulcer was operated on twenty-six hours after perforation and recovered. I saw this case three weeks before in consultation and a diagnosis of infected gall-bladder was made, as the pain by pressure was directly opposite the eighth rib on the right side. The pain after perforation was so severe that it could not be controlled by hypodermics of morphin and chloroform had to be resorted to. The operation was performed at eleven o'clock at night and the abdomen drained with five gauze drains.

Among cases of incarcerated hernia was one case of incarcerated femoral hernia, where the greater part of the omentum had to be removed, and a hernio-laparotomy had to be performed for the purpose of not overlooking an internal strangulation; the patient recovered. In one case of strangulated hernia in an old man whose condition was such that an anesthetic could not be given, the operation was successfully performed under local anesthesia. In another case operated on eight days after the onset of the strangulation (the delay being caused by the patient himself, who was a Scientist), the bowel was found to be gangrenous and an artificial anus was established. Three weeks later, in the same farm-house, two feet of bowel matted together in one

bunch was resected and the ends united by end to end anastomosis. The patient recovered and went to work eight weeks after the operation, somewhat against my will; was struck by a log the first day of his work and sustained a fracture of the pelvis, for which my friend, Dr. Landsborough, treated him, and from which he is now recovering. One case of ileocecal invagination produced by a tumor in a man 50 years of age was observed. At the time of operation general peritonitis had already progressed very far and the patient was in a moribund condition. The man died three hours after operation and possibly no operation should have been performed, as the case was hopeless; but it was our principle that an operation should not be refused any patient as long as there is life and the slightest ray of hope.

There was one interesting case of pregnancy in a contracted pelvis in a dwarf. The contraction of the pelvis was such that only Cesarean section could save the life of the patient. The operation was performed at twelve o'clock at night. After opening the abdomen it was found that there was another interesting congenital anomaly present in our patient, namely, that we had to deal with a pregnancy in a uterus-unicornis, only the tube and ovary on right side being present, while these organs were entirely lacking on the left side. The uterus was opened by a transverse incision through the fundus. The patient made an uninterrupted recovery and both mother and child are well to-day.

There was one case of gun-shot wound of the intestines in a boy 12 years old, who was shot with number five bird shot. There were marks of between fifty and sixty shot, which had entered the buttock; we did not think at first that they had penetrated the abdomen. Later symptoms of peritonitis developed and it was decided to open the abdomen. We found seven perforations of the bowel caused by two of the shot which we found had passed through the ilium causing the perforations. The boy made an excellent recovery.

CONCLUSION

At the end of my paper I once again desire to reiterate: Such excellent results of emergency abdominal surgery could only be achieved by the fact that an expert surgeon performed these operations at the earliest possible moment, within the homes of the patients afflicted, and in doing so we acted according to the principle of the old established law — "*Salus patientis suprema lex medici et chirurgi esto* (the welfare of our patients must be the first law for the actions of the physician and surgeon)."

SYPHILIS, WITH ESPECIAL REFERENCE TO "606" *

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In 1909, Ehrlich, after much experimenting and study, discovered salvarsan—an arsenical compound, a yellow acid powder, easily oxidized to poisonous compounds and peculiarly destructive to the germs of syphilis. It was at first supposed that one or two injections of "606" would cure any case of syphilis. It is now known that such is not the case.

Regarding the virtues of "606" in the cure of syphilis, a great difference of opinion exists. Frank Billings said in June, 1911, "The results from the use of '606' have not been as good as from the use of mercury in my hands." Pusey states, "We may say positively and finally that '606' does not cure syphilis in any more cases than mercury does."

Hundreds of clever scientific and very reliable medical men are to-day claiming marvelous results from the use of salvarsan in cases where mercury was not well tolerated or had utterly failed.

Schaudinn and Hoffmann, in 1905, demonstrated the *Spirochaeta pallida* in syphilitic lesions. These germs are best found in the early stages of syphilis and are present in about three-fourths of the smears taken from chancres, moist papules and mouth lesions. The chances for finding these germs diminish as the secondary symptoms develop. The organism when found and freshly mounted under the microscope can be seen to move. It is a living germ.

Good authorities claim that the finding of this germ by a competent diagnostician in a suspicious sore warrants the commencement of anti-syphilitic treatment. Some authorities go so far as to say that with this very early diagnosis and prompt treatment with salvarsan, we may prevent the secondary symptoms from ever appearing. In other words, we practically abort the disease.

With the disappearance of the chancre and the primary or initial stage of syphilis, the finding of the syphilitic germs becomes more difficult, but fortunately for science, we can, after this stage has passed, resort to the Wassermann test. Wassermann, in 1906, discovered a serum reaction peculiar to syphilis. The Wassermann serum test is a difficult one to make. A positive Wassermann cannot be obtained, as a rule, until the primary sore has appeared and frequently not until the secondary symptoms have developed.

There are a number of unfortunate truths about the Wassermann test. Positive Wassermann reactions are obtained in leprosy, general paralysis of the insane, congenital mental deficiency, relapsing fever, general paralysis, after veronal, morphin, scopolamin and ether narcosis and just before death.

There are great chances of mistakes in making the test. Yet, a positive Wassermann found by a competent demonstrator must be the means of frequently assisting in making a diagnosis or confirming a doubtful one. When found, it often proves that a certain skin lesion, a certain sore throat, or an unusual symptom of pain in any part of the body is syphilitic in origin.

Because of the possibility of mistakes in the laboratory diagnosis of syphilis, it is prudent to have other reasonable grounds for suspicion before beginning with any anti-syphilitic treatment. Failure to carefully consider the clinical symptoms, together with too much confidence in the Wassermann test, or other laboratory findings in the diagnosis of syphilis, must mean that occasionally patients will be subjected to anti-luetic treatment who have never had syphilis. At the same time, I believe that the laboratory findings in the search for syphilis are almost as certain and of fully as great value to us as the laboratory findings in typhoid, diphtheria or tuberculosis.

THE INDICATIONS FOR CAUTION

In what cases should we use special caution in the use of "606"?

(a) Infants with hereditary syphilis, better depend on mercury.

(b) In severe cerebral disease, cardiac affections, low cachectic conditions—as diabetes—and in severe arteriosclerosis, use mercury; and if mercury fails, feel your way carefully with salvarsan.

(c) In early malignant syphilis, cerebral hemorrhage, gastric ulcer and in very old people, go carefully with salvarsan treatments.

IN WHAT CASES IS SALVARSAN POINTEDLY INDICATED?

(a) In cases of syphilis diagnosed very early.

(b) In the treatment of patients who cannot take large enough doses of mercury to control the symptoms.

(c) When the disease progresses in spite of other methods of treatment.

(d) When rapid disappearance of skin and mucous membrane lesions is particularly desirable.

* Read before the Ottawa County Medical Society, March 11, 1913.

METHOD OF ADMINISTRATION

The majority of authors seem to prefer the intravenous method, yet many think the intramuscular method quite as effective, if not more so. Salvarsan would be used intramuscularly much more often but for the severe pain it produces when so administered and because of its liability to cause an abscess at the site of injection. Salvarsan as an intramuscular injection will probably give way to neosalvarsan, because the latter is very much less painful.

No very expensive apparatus is necessary in giving salvarsan intravenously. Select a prominent vein, say, for instance, the basilic or cephalic at the elbow. Make the vein prominent by pressure and plunge the needle directly into it. If the vein cannot be easily found in this way, cut down on it and then pierce with a needle, about a seventeen gauge. Any needle large enough to allow eight ounces of water to flow through it in five or ten minutes will do.

A small glass-barreled syringe with the piston removed and which connects easily with the needle by being pushed into it, is connected with 5 or 6 feet of rubber tubing, at the other end of which a glass funnel is attached. If the needle goes into the vein, blood will drop from it. Have the funnel filled with normal salt solution, which will run down the tubing and escape through the small barreled syringe at the other end. While the blood escapes from the vein through the needle and normal salt solution flows from the syringe, connect the two. In this way no air finds entrance to the vein. Keep the funnel filled with salvarsan solution until all has entered the vein, except that which is in the last two or three feet of tubing. By beginning with the normal salt solution and finishing with the same, no salvarsan is wasted, and by inserting a small glass tube two feet from the needle, it can be easily seen when the injection is completed. Be surgically clean.

Before giving "606" examine the patient for contra-indications, taking the blood-pressure. Give a cathartic the night before, and have him remain in bed a couple of days after receiving the treatment. Usually but little pain will be experienced, unless some of the solution has escaped into the tissues at the point of injection.

Following an injection of salvarsan there may be nausea, diarrhea, headache, chills, fever from 101 to 103 degrees, etc. These symptoms are usually slight and soon disappear.

Sutton of Kansas City states, "During the past twelve months I have seen four cases of hemorrhagic encephalitis, three of these were men who

presented no other evidence of disease except syphilis, yet they died in from two to ten days." It may be possible that in these fatal cases the previous examinations were not made with sufficient care, and through this neglect salvarsan was administered in doses too large for these special cases.

Many medical men are to-day making use of both salvarsan and mercury in their every-day cases of syphilis. The two treatments appear to work well together and many believe the combination gives more rapid and more permanent results.

REPORT OF CASE

A patient came to me complaining of pains which I diagnosed as rheumatic. Ten days later she complained of vaginitis. Syphilis or gonorrhea in this case seemed impossible, but in less than a month the diagnosis of syphilis could not be questioned. She was put on increasing doses of mercury for fifteen days, and becoming dissatisfied with my treatment, she decided to go to her former family physician. He treated her for more than four years. I believe she followed his instructions carefully, and that he was a physician of considerably more than ordinary ability in the treatment of such cases. He gave mercury at first by inunctions, later by the stomach, and as the disease progressed he gave treatments of potassium iodid. The patient responded poorly to treatment and after an absence of a little more than four years, she again returned to me. There were several deep ulcers in the hard palate and in the alveolar processes. Her headaches and head pains were almost unbearable and she had much coryza. Her blood-pressure, pupils and reflexes were, however, practically normal. I tried in vain to relieve her. Cacodylate of soda in 3-grain doses was repeated twenty times hypodermatically. Mercury and enesol were given in the same way in liberal doses. Potassium iodid was faithfully tried in large doses.

Patient again returned to her old family physician, who found her coryza so great that he thought I had overdosed her with potassium iodid. She was sent to the hospital and salvarsan was injected deeply into the muscles of her back. The relief was wonderful and rapid. In less than a week's time she felt that she was cured. The ulcerations in her nose and mouth were almost healed; the coryza and headache were gone.

Six weeks later her old symptoms had reappeared and salvarsan was again given intramuscularly, but with rather less and shorter relief than previously. In two months she appeared to

be as bad as ever and again sought relief from me. I decided to try salvarsan intravenously. Her veins were so poorly defined that I failed three times to pierce the right basilic, but succeeded, or thought I had succeeded, in getting into the right cephalic. The injection was painful during its administration, but as the fluid seemed to disappear freely, I continued. In from fifteen to twenty minutes the arm from the middle of the forearm to the axilla had increased in circumference from one to two inches and her pains were very severe. Four hours later her hands were cold, temperature 100, pulse 70, pains very acute. At the end of two days the arm was still two and one-half inches larger than normal in circumference, but the pain was lessening. The arm remained swollen, hard and edematous for several weeks. Evidently a part of the salvarsan had escaped into the tissues outside the vein.

Hypodermatic doses of mercury in large doses were again given. Her condition continued good until five months later, when I again gave salvarsan intravenously. Being unable to make any of her veins prominent, I cut down on the basilic and found that under pressure it was only about the diameter of a match. No pain followed this injection, but there was fever, nausea and purging as before. Mercury was again commenced hypodermatically and three months later salvarsan was repeated intravenously.

I fully believe that this patient would have died months ago but for "606." The relief it gave was simply wonderful. The ulcerations in the nose and mouth are not completely well, but are very much improved; there is still some slight headache at times, but the patient eats and sleeps well and is able to do the hardest kinds of work. She has had five salvarsan injections inside of one year and is at present using inunctions of mercury.

In this case mercury failed to even check the disease, although faithfully tried and in various preparations by the mouth, by inunction and hypodermatically. Potassium iodid, enesol and cacodylate of soda proved to be utterly worthless here, yet every dose of salvarsan gave quick and astonishing results.

Salvarsan, neosalvarsan or some similar preparation will, I believe, in the near future and when better understood, be universally regarded as one of the great remedies in the treatment of syphilis.

THE COUNTRY PROBATIONER *

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It is rather embarrassing to be obliged at the very outset to admit that the young probationer whom I shall picture is in no way an author's portrait of the author. He is rather that saddest of individuals, "He-might-have-been" as the author after a city perspective of five years is able to see him. And yet not quite that. I shall take one of the better type of men whom our schools graduate; eager, energetic, and not without some wisdom or a considerable cargo of facts. You have all known him. He is of the best we have; and I have chosen him as the vehicle of these observations because in the discovery of opportunities, only the best is valuable. It is of the country as an opportunity that I wish to speak.

Then again, perhaps, I shall be too often tempted to a comparison of the country versus city; yet this is not so much my intention as to establish a thorough conception of the rural location—its advantages, its dangers, and its rewards.

In every large city there are a number of men who have enjoyed a country probation. They are not men who have started in small towns of from 8,000 to 10,000. These seldom move on; they have hospitals, nurses and the best of livings. Rather do I speak of those who have begun practice in villages of from 300 to 2,500, and I take as my example the community of not more than 1,500 as the possible country location for our young man.

I am not interested in expounding the country as a permanent location. It has been done well and sufficiently. It is my desire to present the rural beginning only as a valuable experience, a point of view in addition, rather than as fixed bias. I had best explain, too, that while having been reared in such a community as the one mentioned may discount some of the value of the later experience, yet the commonplace position of the minor in a community and the unique position of the physician in the community is separated by four to six years, at the least, of unique experience in the essentially cosmopolitan and metropolitan atmosphere of the college and hospital; so that I sometimes think that the returning prodigal has as much to learn and less disposition to learn it than the city-bred man.

Moreover, from the standpoint of the public I am convinced that the small community needs the young man. Not only does it furnish him with a valuable opportunity, but the young man fresh from a good training is the opportunity for most small communities. A former president of the Michigan State Grange, who lives in a rural township, once said of his own family problem: "We have a new doctor in our neighborhood about every three or four years, and we are glad of it. In that way we get some very good men hot off the frying-pan." He realized that in most very small communities this was the best that could be expected—a few short years of an ambitious and capable man's life. This of course does not imply that all men who spend a short time in the country and then move on are superior. It simply offers the chance, which this shrewd farmer was able to see. The country needs the young man and the young man needs the

* Read before the Detroit Academy of Medicine, November, 1912.

country; at least I am of the opinion that some of them do.

One frequently sees men of ability, whose future in a city practice depends on the exercise of certain faculties which can be developed or restrained more easily, unconsciously and effectually by the direct methods of the country. I only wish the country probationer might take up his work with a full appreciation of his opportunity, and the ultimate advantage in its severe methods. I believe the profession has a very indifferent conception of the breadth of the rural experience. One too frequently hears the superior country doctor spoken of as if he were superior in spite of the country. I believe that this may always be said of the city as well.

I am asking you, therefore, to consider for a few minutes some of the developmental conditions which confront the young man who drops off a local train at a village stop in Michigan, for instance, a good training in his head, a fair equipment, a desire to succeed in the best sense, and last, but not least, a little wisdom.

To judge of results and methods, one must first have a clear idea of what is desired of the young practitioner beyond those acquirements already mentioned; and from the various addresses to graduating classes in medicine, it is apparent that the profession agrees pretty well as to aims. Dr. Osler always puts things in a telling way and I quote from one of his addresses to the budding profession:

"In the first place," he declares, "in the physician or surgeon no quality takes rank with imperturbability." "Imperturbability" he defines as a bodily virtue expressing coolness, presence of mind under all circumstances, clearness of judgment in moments of grave peril, immobility, impassiveness, phlegm." "In its full development," he affirms, "it has the nature of a divine gift, a blessing to the possessor, a comfort to all who come in contact with it. Educate your nerve centers," he continues. "Cultivate such a judicious measure of obtuseness as will enable you to meet the exigencies of practice with firmness and courage, without at the same time hardening the human heart by which we live."

"In the second place," continues Dr. Osler, "there is the mental equivalent of this bodily endowment—equanimity. Natural temperament has much to do with its development, but a clear knowledge of our relation to our fellow creatures and the work of life is indispensable. One of the first essentials is not to expect too much of the people among whom you dwell."

With these theories in mind, I shall endeavor to explain my conviction that any country practice will develop "imperturbability" in less time and with less danger of hardening the human heart than the usual city practice, and that the development of mental equanimity through a clear knowledge of our fellow creatures and the work of life is the certain reward of the country practitioner.

But this is not all. In another address says Dr. Osler: "Let us talk of the influences which may make you good students, now and during your practice. In the first place, acquire early the 'Art of Detachment,' by which I mean the faculty of isolating yourselves from the pursuits and pleasures incident to youth. Of special importance is this gift to the young man who resides for the first time in a large city, the

many attractions of which offer a serious obstacle to this acquisition."

It is my pleasure to believe on my part, that as here intimated the "Art of Detachment" is nowhere so easily cultivated as a permanent and grateful state of mind as in the country.

"In the second place," continues the doctor, "cultivate the virtue of method." Of this I shall also speak.

"In the third place, develop the quality of thoroughness." "Thoroughness," he explains, "means the knowledge of the fundamental sciences, chemistry, anatomy and physiology, not a smattering, but a full and deep acquaintance, not with all the facts—that is impossible—but with the great principles based on them. You should as students reach in these three essential studies a degree of accuracy which is the true preparation for your life studies." I shall attempt to show that nowhere is the young man brought more face to face with his fundamentals, made more thoroughly aware of their paramount value, than in the isolation of a rural practice.

"And lastly," says Dr. Osler, "the grace of humility." Personally I believe, and I shall try to explain, that this is a most subtle influence of rural life; that to begin one's labors in a country community will cultivate in a man *capable* of humility the very *essence* of humility, especially if he is city bred.

But withal, I must again remind you that as in all opportunities the result is dependent on the ability of the individual to react to his opportunities; and his ability in this direction is the sum of his natural gifts and their thorough cultivation. When I speak of the country as the man's opportunity, I speak of it always with Dr. Osler's own qualification, "if he has it in him."

Now let me take you to the country, not as a summer boarder, not as a consultant, but as the young man I have just described; well prepared, zealous, with fresh enthusiasm as you were the day you took up private practice. Let us say that the village is fifty miles from a medical center of any size. The train stops; you take up your luggage and emerge. Hardly does one set foot on the little platform before one begins to cultivate "imperturbability," "equanimity," the "art of detachment," and the "grace of humility" no less. The village wags cling to the lea side of every railway station and they are not speechless. If you have a leaning toward tan shoes and red neckties, you soon discard them as non-essentials.

One fact must be kept constantly in mind: the rural system of education is one of direct methods; always direct, always uncompromising. When you can contemplate the human relation as it exists between physician and public, in that light you are prepared to view the country doctor's experience with an understanding not at all possible otherwise.

And now our young aspirant moves round the station. That stretch of landscape is no field of white beds with nurses and doctors for landmarks; rather it is a small cluster of enigmatical human shelters and waste spaces. One's first sensation is that of utter aloofness, loneliness and superfluity. Equanimity wins or loses a point here, according to the man.

But this system of direct shocks and an open field has its advantages. There is a miracle over night. Ten miles along every pike road his name has traveled. Everybody in and far beyond that wide horizon

knows that a new doctor has come to town. By the next night they know that he has taken offices over the bank, and by the next night he will have a clientele, a small one of incurables perhaps, but a clientele no less. This is not an extravagant statement; I could prove it if it were necessary. There *are* fields which are so abundant in material that they are dangerous places for the young man, but these are not common. The real cause for the immediate employment is the ease with which the few who do need the new physician have learned of his advent.

Now, after three days let us take stock of our young man again. He *still* has twenty-four hours in his day; he still has his natural abilities, his training and he has added, say, two chronic cases. His office is new, his equipment is new, and these constitute not only his workshop but his home in ninety-nine cases out of a hundred. His reputation is a clean slate. He has made no friends to amuse him, and there are no billboards to lure him. His only connections with his world at that time are the two cases. I ask you what he is going to do? There can be no doubt about it; he is going to work with a relish. The art of detachment which Dr. Osler emphasizes for the city man gives place in the country to the habit of attachment; not a negative virtue, but a positive necessity. Our young man is going to work. On the one hand is the patient, victim of many nostrums; on the other hand are those saving books, those new tools; and between them himself, his hands and the store of their knowledge. Beyond these four walls there is nothing; no intimate, jostling world, no professional peers in the offing, waiting to support him and protect him. Indeed, he is alone; closeted with an opportunity. This is a very effective way of achieving the "Art of Detachment."

There is probably nothing more difficult to accomplish in the practice of general medicine than method. I am speaking now of system in the management of one's day, one's accounts, etc. The country will not assist a man in this more than the city, perhaps less. One's time is borrowed in large chunks for long drives, whose times and seasons cannot be controlled. Office hours are hard to keep, but they may be observed to a considerable extent if one appreciates the value of divided time and its chances for improvement. As to the other phase of method, that which bears on the observation of patients and the treatment of them, I can only say, and I believe that the conclusion is the general opinion and experience of the profession, that Science with a capital "S" is a first love. A man is either bound or free when he leaves his college and hospital training, according to his own temper and abilities, plus the scientific impress of his training, through the spirit and devotion of his instructors. If he leaves the companionship and leadership of scientific men with a fair appreciation of the relationship of the fundamental sciences to his art as an interpretation, he is bound for all time; but if he begins private practice without this any later alliance is usually a superficial expediency. I should say that the young man who goes into the country with a clear appreciation of scientific method will emerge with but a stronger faith in it. Everything in the country as well as the city is possible to the man who starts with a system which makes it possible for him to classify his results. A more comprehensive training in diagnostics than the good village

practice affords cannot be found anywhere; and there is the time and the seclusion necessary. But much depends on the young man's attitude at this period. Your *futile* personality will be irked by the unfamiliar loneliness and isolation, and will allow itself to deplore the peculiar conditions limiting the effectiveness of his results, also the scarcity of material for observation. *He* is no man for this opportunity. But the wise, ready man will scarcely be conscious of his handicaps, sensing only the opportunities before him. He will enter on his lonely beginnings with the zest of adventure and the relish for work which individual, unaided achievement always arouses. In but a few days he will feel at home in his office, in the humble companionship of his base burner and his books, and will begin to feel the subtle presence of his neighborhood, its habits and thought.

And now as to "Thoroughness." Dr. Osler has described it as a full and deep acquaintance with the fundamental sciences on which our art is based. Again this fulness and depth depends: first, on the young man; second, on his education; and third, on the further illumination of his later experience. It is possible that even the first-rate intellect may sometimes suffer from indigestion, where the fare is too high and the opportunities to try this and that are unlimited. After all, one's procedure is effectual in direct relation to the clearness with which one discovers fundamentals through the mass of incidentals. This fact is soon forced on even the *half* observing country practitioner. He finds that his fundamentals are his salvation. For, though he will have many unexpected facts to conform to line, being alone, and without the hope of advice from the more "well-conned" of his profession, he will begin to pin his faith more and more to his fundamentals. In a small, diverse clinic with no consulting colleagues, he will learn that a great deal of special case literature is beside the point for him, dangerous to his clearest vision, until he has developed a technic which is daily more responsible to a fuller acquaintance with the fundamentals of chemistry, anatomy and physiology.

There is another special phase of the rural point of view which bears on this recognition of fundamentals, and which I shall now take up under that mental quality—"equanimity."

Mr. Kipling, in his "Conversion of Aurelian McGoggin," makes the following observations regarding city versus country life on one's grasp of fundamentals. He says of Aurelian in his clear pictorial style:

"I do not say a word against his creed. It was made up in a town where there was nothing but machinery and asphalt and buildings all shut in by fog. Naturally a man grows to think that there is no one higher than himself and that the metropolitan board of works made everything. But in this country where you really see humanity—raw, brown, naked humanity—with nothing between it and the blazing sky and only the used-up overhauled earth under foot, the notion somehow dies away, and most folk come back to simpler theories." . . . "At home," he goes on—meaning England—"men are to be excused. They are stalled up a good deal and get intellectually 'beany.'" Now, I do not mean to imply that all city practitioners are intellectually "beany"; I only wish to say that it is a possibility in the city and almost an utter impossibility in the country. By Mr. Kipling's use of the word "beany" I gather that he intends

to imply that being stalled up, as it were, in a steel-concrete, fireproof building has its dangers. Such a man may acquire a great deal too much faith in himself and institutions and may grow to think of himself as a very particular institute. He may feel justified for great faith in himself because he has great faith in the institutions which made him, and he knows that the public accepts much the same easy persuasion. But, perhaps most precarious of all to the young man, is the steel-concrete, twelfth-story view of life. Metaphors are dangerous things, but I make bold to employ this one. It takes a peculiarly long-sighted man to supply the advantage of a ground-level practice at the beginning. There is something naked, "able-to-stand-alone" about a practice which admits of consultation at the end of a plow furrow and must employ scientific principles as best it may, without the marvelous artifices of science. There is something wonderfully direct and to the point about one's mental processes under the influence of a wide horizon; at least those persons who seem to have had the greatest success in this line have always said so.

Let us see, then, just how these conditions bear on Dr. Osler's recommendations. He says that "equanimity" is largely dependent on a clear knowledge of our relation to our fellow-men and the work of life. A clear knowledge presupposes a firm grasp of fundamentals in the human relation as elsewhere; and the human relation, as observed in the country, has all the advantages of a close range and a small field. The man of more or less lively observation, who consciously watches the flow of another's thought or the trend of a community's mind, must find the country as the astronomer finds the clear night. It is a mistake to speak of such experience as observing human nature in the rough. It is rather observing human nature at a comprehensive range and in intimate association. It is living *in*, as well as ministering *to*, one's clientele.

Can you imagine for an instant what kind of training in equanimity is thus forced on the young man? Just one of the things that he learns is that it is wise to keep his affairs and the affairs of others to himself. If he had taken Mrs. Jones to the four corners to paint her back with iodine, the populace could not be better informed as to just the area decorated. Whatever one's experience with individual cases, country doctors as a class are perforce close-mouthed. Even the little harmless things which one hears slip out of the city doctor's experience are unknown in the country. One may throw a burning match into Woodward avenue with impunity, but not into dry grass and underbrush. The personal danger is about equal. It has driven more than one man from his field. The habit of silence concerning one's work is a valuable habit anywhere; in the country it is positively remunerative, which is a great incentive to its formation. It is, moreover, an excellent beginning in "equanimity."

Such publicity not only teaches him to keep his own peace but it will train him to act according to the dictates of his own intelligence and conscience, with the cries of the multitude in his ears. Nobody will save his ears. In consultation he will be obliged to sit patiently while the patient relieves himself of the town talk about his evil ways and evident failures. Now and then the gossip is flattering and more agreeable, but the country is not given much to flattery. This sort of thing has a very healthy effect on the timid, puttering conscience with which so many

exceedingly good young men start out. I might almost interpret Dr. Osler's "Equanimity" as a forthright conscience; one which has ceased its juvenile mutterings and speaks with unconscious authority. There are many phases of country practice which develop this and the very catholic nature of one's public is one of them. One's conscience may not always go hand in hand with wisdom, but at least it gets good practice in public performance and unshiftable responsibility. I shall not take time to argue the point, but I can assure you that the country is certainly not more gullible than the city, and there is much less chance for the unscrupulous man to hide himself in the intellectual limitations of a class or neighborhood. Everybody knows him in the country, and also knows all of his patients, rich and poor, wise and foolish, and how he treats them. But, as you without doubt realize, the most significant fact in this connection is that the young man has no one to whom he may turn in the hour when his conscience begins to shirk. There are no consultants within reach of many of his most urgent demands; he may have only himself to blame; only his own judgment for appeal. I say the young man in the country must meet and grapple with these situations early and strenuously, if he has a disposition to succeed on his merits; and he will do it with "equanimity" or not at all.

And now what of "imperturbability"—that immediate and saving grace? We are warned that we must cultivate our nerve centers and *that* without hardening the human heart by which we live. A country clinic is a very entertaining clinic. It has all the spice of adventure. One comes back to the office from one section of the country and finds an almost undecipherable scrawl on the slate, bidding him come somewhere, ten, fifteen miles into the wilds. Every mile is one mile farther from assistance, save from his own mind and the few instruments which he may carry with him. He may find anything from a well-developed case of a contagious or infectious nature to a serious injury. He may be called on speedily to do any small petty thing or work of such grave significance as only the specially trained man has any license to do in the city. Of course, all general practitioners have more or less of this; but the city man knows where to get trained help and advice on short notice; for the man in the country, there is no such alternative. If he is fresh from a good training he is likely the best man in sight and soon knows it. But he need not become vain about it. The country will not put up with vanity in any form. At all times he must comport himself with respect to everybody and yet take all the mental and moral responsibility. There are not even efficient nurses. More than that, people in the country avoid a doctor until the last minute. It is the customary thing to arrive in the middle of the third act when the action is critical and everybody is over-excited. This does not give much time to professional perturbation. The most timid greenhorn will forget the audience, forget everything save the work before him. By sheer necessity of assuming all the responsibility he will automatically submit his behavior to the best of his mental perceptions and dictations. I do not mean to say that these things do not happen in the city; I only mean to say that they do not happen so often and there are a thousand more ways to turn. Repetition of such situations soon diminishes one's self-consciousness and develops one's nerve centers. The young man's first

thought when he finds himself for the first time, ten miles in the country and confronted with a critical, more or less blind case, is: "Oh for my books." His next is to get himself together without them. I believe the pedagogues say, make all pupils rise to their feet before the question is put; they will give a much better percentage of recitation. That is what happens here. The question cannot be passed on while the young man sits in his seat and shakes his head. His name was called: he got up before he knew the question; and through sheer necessity he begins to remember. I think most men will admit that they can remember much more than they give themselves credit for, when they find themselves in a tight place. The country doctor is, relatively speaking, always in a tight place. He must call up memories of facts, pictures, sounds, odors, sensations of all kinds, with rapid precision; accept, discard in his own intellect, without assistance, without advice. Also, he must gather his histories carefully, in explicit language. He must take nothing for granted. The country patient is notoriously non-committal. And lastly he must act. A great deal depends on mere mechanical ingenuity. Conditions are often of the worst and facilities the most meager. There are no perfection sterilizers. There are only the simplest devices for housekeeping, if there are those. The city hovel gives way most often to the well-appointed hospital. To find oneself in a log hut, the wheat crop in one corner, the patient in another—poulticed with cow-manure or warm chicken entrails—lying on a dirty bed, and attended only by a family of seven who speak exclusively Bohemian—that is quite another matter, I assure you. I have chosen a rather extreme case, I admit; but I could vouch for the truth of it and the unlimited variety of possibilities. If this sort of thing will not develop imperturbability, it must surely develop patience and teach one not to expect too much of the people among whom one lives. As Dr. Osler says, this should be one of our first lessons. It takes unbounded patience for a man with a scientific training to practice his art under such conditions.

And what of that other warning that we must acquire "imperturbability," "equanimity," and all that they imply, "without hardening the human heart by which we live"? By this I gather that our worthy mentor intends that this shall be done without numbing one's moral sensibilities or losing the gift of affection. Is there any question that both one's moral sensibilities and one's affections are more largely dependent on clear understanding of the individual or the community than on any other quality, save innate greatness? It takes a great mind, certainly, and a great heart to grasp and feel keen, moral responsibilities and human affection for the patient who reaches out a hand to him across an abyss of unknown experiences, interests, ambitions and limitations. And this is the common condition of a city practice. But what does the country doctor know of his patients? Everything, almost without being told. They are neighbors, friends. He knows them as they are, and as they would like to be. I believe this hastens much the young man's conception of his "relation to his fellow-men and the work of life"; adds much to his sincerity and absorption in his service. Nobody learns so quickly as the observing young country doctor, that there can never be two men, the man *and* the doctor, but only one man *in* the doctor. Personally, I believe that every man who comes to the city from the coun-

try would tell you that this intimate understanding of one's community, which keeps up the tone of one's moral responsibilities and breadth of one's affections, is the very crest of the rural experience. The scope of this experience is simply indescribable to the city man. *He* may know the secrets of many a heart and mind and body, but the rural practitioner knows the secrets of a tiny commonwealth of hearts, minds and bodies. The whole and its parts in their wonderful, compact relation is laid out as nearly within his grasp and understanding as the human relation can be displayed, and medical science is bound hand and foot with the fetters of this relation. I would say to the young men going into the country, as I wish someone had said to me: "If there is anything as interesting and helpful as human anatomy and physiology it is the anatomy and the physiology of society. Study your small field eagerly, analyze it thoughtfully, remembering that human nature is the same in Podunk as in Detroit or Grand Rapids or New York, and in the old Adam as in either of them."

I have tried to explain to you my belief that the developmental influences of a strictly rural practice will cultivate the habit of detachment and respect for fundamentals. More than that, those influences possess all the essentials of a pioneer struggle, and the word pioneer is always suggestive of self-sufficiency. The early cultivation of this quality may not seem worth the trouble at the expense of some things which the city opportunity affords. If this be the case, at least I may perhaps have portrayed the rural location as not so unfruitful as the young man may imagine.

But now, before leaving the subject, I cannot forbear to speak of those things which some are pleased to call the softer influences of our daily experience. In this case I shall speak briefly of them as the charms of the country.

First, there is simplicity. One's idea of essentials is not so befogged with shop-window possibilities. One learns the possibility and comfort of traveling light on the journey of life. I believe this is one of the reasons why such a large percentage of successful men in our medical centers are of rural origin. Then there is another charm of rural practice. Perhaps I should say that it is the most inspiring and life-giving of all in these first years of daily companionship with sorrow and suffering. It is what Osler calls the "Poetry of the commonplace; of the ordinary man and the plain toil-worn woman."

May I be personal for a minute, since these experiences are by nature personal. One of my most happy bits of country remembrance concerns one of my first cases. A delirious old work-worn woman was calling for the "kid." She had a good many kids, so I asked her which one. "Why the kid doctor," she said. This was the beginning of many humiliations I suffered at their friendly, tolerant hands. Particularly significant also to me is that the last person I saw as my train pulled out of the village for the last time was our wash-woman. I had healed up a long standing sore on her leg and she had proclaimed publicly and privately, in a loud voice, that "I 'vas de mos' vunderful doctor in de vorl." On the day I left she came out on a bleak, treeless bluff to wave me a good-bye. The gesticulations of her great red arms and the radiance of her great toothless grin make one of the sustaining pictures of my life—sentimental though that may seem. Every country doctor treasures such memories of incomparably wholesome, daily

friendship with unaffected souls on the level of communal life.

Then one cannot pass by rural humor without paying his due. It is the most spontaneous, refreshing and wholesome humor in the world. It strikes you, bowls you over like a huge salt comber, and it takes some few trials to come up smiling. It toughens the skin and knocks a man into shape.

And after all there is that other charm, especially to the eager, inquiring mind, the daily companionship with nature. I do not mean that one gets into any poetic "mooning" over it. But for instance, weather in the city is a thing largely of paper and printer's ink, physical comfort and discomfort; while in the country it is a very companionable thing of sun and wind and rain and friendly prophesy—all the fundamentals of weather. In the country one sees the weather come from afar off; sees it blast his hopes of a last payment on a typhoid case; or literally wrench the crops out of the ground with good nature. One cannot help learning to watch things grow and to interest himself in the ways of vegetation and the lower animals. When the wheat comes to town the checkbook comes on the front seat. When the stuck pig howls in the barnyard the checkbook is again moved to generosity, and again when the flock is led to the shearing. The country doctor's bank account is the sign of the times, not the rise or fall of mere mechanical industries, but the more incomprehensible times and seasons of the inscrutable industries of nature. And more than this, I am sure that any "once country doctor" will say with Keats of 'Nature's glories infinite':

"Nor do we merely feel these essences

For one short hour; —————."

but they

"Haunt us till they become a cheering light

Unto our souls, and bound to us so fast,

That, whether there be shine or gloom o'ercast,

They always must be with us or we die."

And they are always with us, on Woodward avenue, on Hastings street, or through a five-story window; the south wind never loses its identity, nor a wet moon, nor good corn weather.

But why, after all, should the small rural community be only a probation? First, for the same reason that even the city doctor, who won't get into a rut must travel. Our faithful young man after three or four years, through faithful self-struggle and improvement should deserve the relief of hospital aid and must have begun to need the stimulus of more exacting competition, to say nothing of the inspiration and companionship of his peers. Let us hope that in the too small village he is only a probationer; alive to his present opportunities and his future. But if for some reason he cannot leave his first field for more than the frequent visit to the medical center, there are compensations and possibilities. Even such limited returns to study and the companionship of great men and great clinics are like the Christmas feasts to the news boy. He may have eaten his fill of fundamentals every day of his life, but it is the feast and the fellows which lift him to another plane, brighten his eye and tickle his wit. As Mr. Arnold Bennett says of all feasting: "One eats and drinks to excess, not because it is one's custom to eat and drink to excess, but from sheer effervescent faith in an idea." I know

of no better description of the table which the "corn-fed doctor" finds spread for him in the medical center, nor the new inspiration and faith in his science which it affords him.

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REMOVAL OF FOREIGN BODIES FROM THE EYE; WITH REPORT OF THREE CASES *

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Removal of foreign bodies from the eye is a problem ever before the oculist. Such foreign bodies may be divided into three classes, those non-penetrating, those penetrating within the globe, and those penetrating the orbital tissues, but not the globe.

NON-PENETRATING

Non-penetrating foreign bodies are, of course, the most common and usually present no difficulties of removal—a little cocain, a sharp scoop or the tip of a cataract knife—if imbedded in the cornea or conjunctiva. Sometimes the foreign body is merely under the lid, or lodged in some place on the conjunctiva, and may be removed by a cotton-tipped applicator.

These substances, by their scratching and irritation, cause much pain and often set up a severe conjunctivitis, which usually will disappear after removal of the foreign body, and instillation of adrenalin, followed by some mild antiseptic until the injured conjunctiva has opportunity to repair. More severe inflammation and ulcers resulting from the too long presence of foreign bodies; cinders, steel, emery, etc., demand careful attention.

With the usual non-penetrating foreign body we have little trouble, but I would caution the operator to be sure that not only the foreign body is removed, but also the burnt tissue, rust or other debris. I have seen many cases where the foreign body was removed, but not the debris, burnt tissue, rust or whatsoever, resulting in severe conjunctivitis or ulcer. These results usually are in persons who had the foreign body removed in some shop by a fellow workman with a keratome (or jack-knife) and cocain kept for the purpose.

One of the most difficult non-penetrating foreign bodies to remove is the barbed beard from grains, barley in particular. These barbed beards have a creeping and penetrating perversity.

* Read before the Calhoun County Medical Society, Feb. 4, 1913, at Battle Creek.

CASE REPORTS

CASE 1.—M. C. L., Dec. 23, 1911. Patient consulted me for a swollen and very painful eye which had developed following working in barley straw. I found a deeply injected and swollen conjunctiva, a hazy cornea, with a large ulcer in the upper nasal area, and after close inspection found a barley beard imbedded in the cornea—nearly penetrating. I grasped the offender with small forceps, but could not remove it without dissecting the whole thing out. After thorough disinfection with bichloride of mercury at first, later sulphate of zinc as an antiseptic, and with liberal use of adrenalin, the eye cleared up, leaving a facet.

Foreign bodies deeply imbedded, but not penetrating into the globe may cause very confusing symptoms—as witness:

CASE 2.—T. C., aged 46. Patient consulted me for glasses Aug. 24, 1912. Had worn glasses, but lost them sometime previously. I found: Left eye, 20/20 vision and accepts no lens. Right eye, 20/200, accepted—25—75 axis $180^\circ=20/25$. However, this test was not clear cut, patient accepting Aug. 26—1.00—50 axis $180^\circ=20/30$. On several days I secured different tests—no two alike, indicating ciliary spasm. I noticed a black spot on the sclera internal to the cornea and about $3/16$ inch distant. On asking patient about this speck (nearly 1 mm. in diameter) I found that about six weeks previously he had been hit in the eye with a piece of metal, which he supposed had been removed by a fellow workman, but the eye was sore for some time. Since the injury he had been having “flashes of light.”

I made a slight incision and felt a metallic substance, which was dissected out. It was deep in the sclera over the ciliary region. The injury promptly healed, and soon after I was able to fit lenses without difficulty: O. D.—1.50—+50 axis $90^\circ=20/25$.

I believe the irritation of this piece of metal was responsible for ciliary spasm, which prevented properly fitting glasses.¹

PENETRATING

The removal of foreign bodies of the remaining two classes offers much difficulty, and each case is a problem of itself. If the offending particle has not entered the globe, the injury is usually less severe, but that all depends on what the offending particle is, its exact course of travel and location, the severity of the blow, and the presence of infection.

In penetrating injuries, always suspect that the offending body is retained, until its absence has been proven. This is the advice of most of the writers on this subject, and is especially valuable in view of the increasing number of malpractice suits, and of the likelihood of sympathetic ophthalmia.

1. May 22, 1913, this patient consulted me about this eye, complaining of falling vision for two months. The lens is hazy with a distinct iris shadow, and a white reflex with oblique light. Retinal reflex indistinct, with a dark spot in center—a beginning cataract. Whether this is traumatic I do not know, but think it is. The other eye is normal.

The hand or giant eye magnet may be used for diagnostic purposes (if the offending material be a magnetic substance), to determine the presence and probable position of the intruder. Pain or a sense of pulling will indicate the presence of a magnetic body, but the absence of this pain or sense of pulling is not presumptive of the absence of the offending foreign body.

If the magnet diagnosis is positive, the removal may be proceeded with at once, but if negative, localization by the x-ray is indicated.

When the presence and position of the foreign body has been determined, removal is the next problem, whether the particle has lodged within the globe or not. If the globe is not injured the prognosis for a seeing eye is good, unless of course, the nerves are injured.

The giant magnet is used to remove magnetic matter—with incision or enlarging the entrance wound, providing the intruder is in such a position that such removal is safe and will injure no vital part. This must be left to the judgment of the surgeon.

If the particle has penetrated the globe, much or little damage may already have been done, depending on the point and direction of entrance, the size and form of the offender and the depth of penetration. Small particles penetrating the cornea and lodging in the anterior chamber, will usually not produce severe damage, unless by the force of the blow (which may produce rupture, dislocation of the lens or detachment of the retina); by the scar formation in healing of the wound which might be in the pupillary region; or by infection.

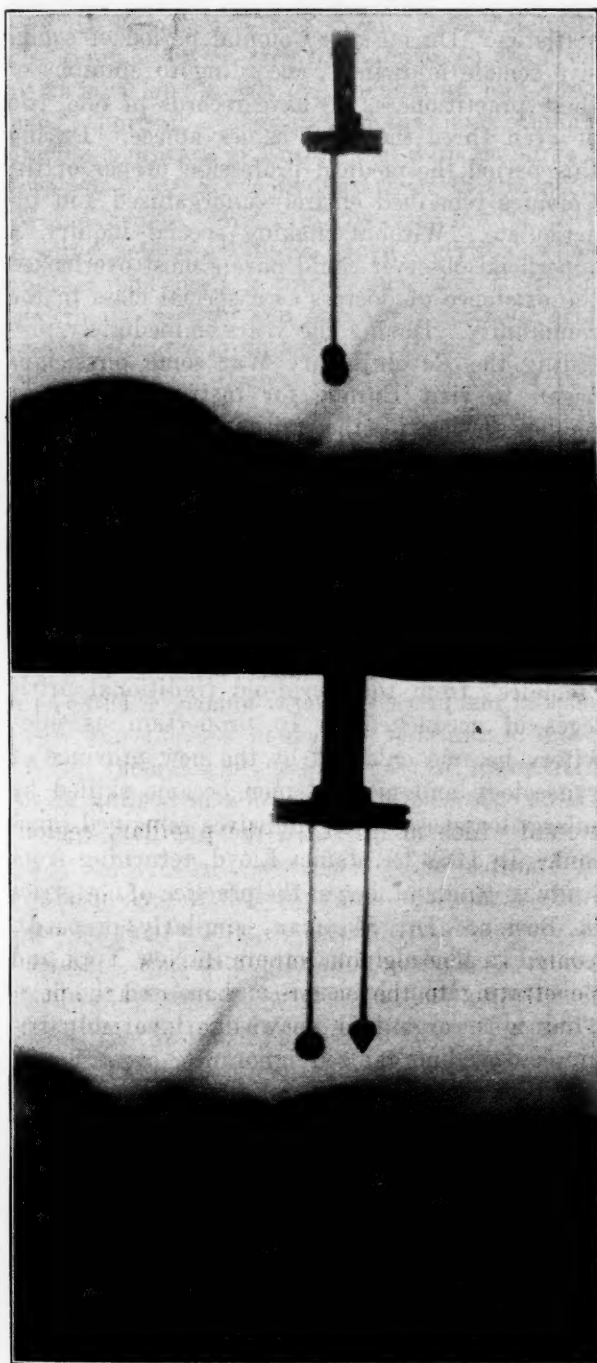
Penetration to and injury of the iris produces its own peculiar results—pain, tumor or coloboma, depending on circumstances. Objects penetrating to the posterior chamber are apt to produce more trouble, because of the injury to the iris or ciliary body, and of likelihood of injury to the lens. Penetration of the lens, ever so little, or rupture of the capsule will almost universally produce more or less complete traumatic cataract.

Penetration into the vitreous and deeper portions of the eye is a serious matter, demanding removal, or probable enucleation.

There is much difference of opinion regarding the methods of removal of foreign bodies from the globe, but all agree on the necessity for prompt removal with as little trauma as possible. It is true that foreign bodies have been known to remain in the eye for months and years without appreciable harm, but the exceptions are so few as to serve only to prove the rule.

Fuchs in his latest text-book on ophthalmology says:

"The attempt to remove a foreign body which has penetrated into the eye is often beset with great difficulties and very frequently is unsuccessful. . . . Almost every individual case has its peculiarities and calls for an operation devised especially for itself."



It is not my intention to go exhaustively into the methods of removal of foreign bodies, but to speak of one or two interesting points. Almost all text-book authors recommend that where the foreign body is in the vitreous, or deeper structures, it be drawn forward by the giant magnet,

to the posterior of the lens, when it is worked around through the suspensory ligament, and to the anterior chamber through the pupillary area, there to be removed through a small slit or T-shaped incision. Lamb of Cincinnati and others, recommend instead that the offender be removed through a sclerotomy incision at the most accessible point and behind the ciliary region, thus avoiding injury to the lens, suspensory ligament or ciliary body.

Text-book instructions on using the magnet are to "make" and "break" the current frequently, thus accelerating the "pull." In this connection, I have a suggestion, which in the case I am about to report, worked admirably. By attaching the rheostat or the magnet to the commercial alternating current we secure just as strong a "pull" from the magnet, and we obtain the benefit of the 60-cycle current giving very rapid "makes" and "breaks." Where the small hand magnet is being used, or the tip attached to the giant is inserted into the eyeball in the final extraction this 60-cycle current is of especial value in telling the operator at once whether the instrument is in contact with the metal, both by the sound and by the "feel." This suggestion, so far as I know, is new—I can find no report of its previous use and offer it for what it is worth.

CASE 3.—C. V. K., aged 36; machinist. While working in a shop, at about 5 p. m., Saturday, Oct. 26, 1912, bending a piece of hot iron pipe, a splinter flew from the pipe which he held directly in front of his face and about 8 to 10 inches distant, striking him in the right eye. Patient consulted Dr. Dullam, who referred him to me at about 8 p. m. the same evening.

He complained of intense pain in the eye and side of the head. I could see a piece of metal imbedded in the iris, extending deeper and nearly horizontally across the upper part of the upper outer quadrant. Vision, fingers; eye very sensitive to light. A small incision was made at the point of entrance, and an attempt made to remove the metal by forceps under cocaine anesthesia, Dr. W. H. Haughey assisting. We worked about half an hour, diligently, but were unable to get hold of the metal without injury to the iris, so suspended operations to get the use of a magnet. A large horseshoe-shaped magnet was found at the sanitarium, where the patient was taken, and with the added assistance of Drs. Colver and Vandervoort another attempt was made to remove the metal. We were unsuccessful in the use of the large magnet, even after we tried to conduct the lines of magnetic force to the eye by means of steel bars. We worked some time with the magnet and with forceps, but unsuccessfully.

During manipulation the iris was torn at the position of the foreign body, which latter we were then unable to see. We were not sure whether the foreign body was removed on the steel bars, as all pain was suddenly relieved and patient felt better. Not find-

ing the iron, however, a compress was applied, patient was taken home, and a magnet was ordered from the dealers. An X-ray was taken by Dr. J. T. Case, for the sake of localization, Sweet's method indicating the center of the foreign body at about 4.5 mm. to the right of the vertical meridian, 4.5 mm. above the horizontal meridian and 3 or 4 mm. posterior to a line through the anterior surface of the cornea, size apparently about 5 by 1 by .8 mm. This placed the center of the foreign body in the posterior chamber.

Wednesday afternoon, October 30, magnet having arrived from Chicago, a large incision was made through the upper two-fifths of the cornea at the limbus as for a cataract operation, the tip of the magnet was inserted in the incision and came in contact below the iris with the metal which was sticking into the lens. The iron was gradually worked outwards until we could grasp it with a forceps and remove it.

Using the alternating current enabled us to tell immediately when the tip of the magnet came in contact with the metal, by sound and by "feel," and told us also the moment magnet let go, so that we could go back for the intruder without taking the magnet tip out of the eye.

The metal is a piece of iron $5\frac{1}{4}$ mm. long, about $1\frac{1}{4}$ mm. wide at one end and tapering to a point at the other. It is about $\frac{3}{4}$ mm. thick with angular surface, rusty and scaly as if a chip from a rusty iron.

At first the patient could see shadows. November 1 patient complained that he could not see at all. The first few days I could see some retinal vessels, but not at this time. No increased tension at any time; no iritis, or iridocyclitis. Atropin was used constantly until November 5, when the pupil was allowed to contract, to determine the amount of deformity of the iris—a coloboma in upper outer quadrant.

Jan. 10, 1913. Patient is blind in the injured eye, having projection only. A cataractous lens is visible, a white spot showing on raising upper lid. Without raising upper lid one would not know that the eye had suffered an injury.

This patient states that he has been advised by others to have the cataract "needled" to restore his sight, but I have not advised this for two reasons: First, there is an element of danger in all cataract operations and his eye is now not unsightly. Second, useful vision would not be restored, merely a larger field. A cataract lens would be required before this eye, giving an image on the retina which would not fuse with that of the normal eye.

In case he loses the other eye this eye would be serviceable after removal of the cataract.

WOMEN PHYSICIANS OF MICHIGAN

FRANCES A. RUTHERFORD, M.D.

GRAND RAPIDS, MICH.

No great structure is ever planned without making sure there is a reasonable hope of a solid and permanent foundation. Our present theme, Medical Women of Michigan, is no exception to the rule. These modern Athenas did not spring

full armed from the head of Zeus. It is of interest that the way was prepared by the women of America, England and France with many examples of awakened determination for broader education among women in Italy, Germany, Spain and Russia, in fact, throughout the civilized world, did we choose to quote history. For our purpose, United States can furnish sufficient statistics. During the Colonial period of exclusive female midwifery, according to epitaphs of these practitioners, we have records of one, two or even three thousand babies apiece. During this period the medical profession proper of the Colonies remained entirely unorganized and inarticulate. Without making special inquiry, a superficial observer could have almost overlooked the existence of doctors as a special class in the community. During the years immediately preceding the Revolutionary War some physicians began to visit Europe for instruction. Their public service in the military hospitals later served to bring the profession for the first time out of obscurity, and the opportunities offered for the collective observation of diseases on a large scale first breathed the spirit of medical science into the American profession.

The first achievement of the new-born interest in medical art and education was the expulsion of "females" from the world-old traditional privileges of accoucheurs. In proportion as midwifery became enlarged by the new province of gynecology and medical men became skilled by enlarged opportunities, midwives remained ignorant. In 1762 Dr. James Lloyd, returning from study in England, began the practice of obstetrics in Boston. Dr. Shipman, similarly prepared, located in Philadelphia, others in New York and Baltimore. Men physicians monopolized the field. Thus must organized knowledge invariably triumph over unorganized ignorance, even though tradition, decorum and religion all be on the losing side. History chronicles events which mark especial epochs.

Since the beginning of our century of peace from foreign foes, women born during the years from 1815 to 1840 have in their maturity changed the outlook throughout the world and prepared the way for women as an intellectual and industrial factor. We in no sense belittle the marked capabilities of women prior to these years, but the Liberty Bell rang out the song of victory and equality for all. Selah!

As example: In England Queen Victoria and Elizabeth Fry had preceded Florence Nightingale in the effort to establish skilled nursing. Elizabeth Barrett Browning had written the cry

of the children. La Maternité in Paris led the world in knowledge of obstetrics and gynecology. Rosa Bonheur, the skilled artist, and others in every avenue of philanthropy and usefulness formed a royal procession of women who began real personal activity in the active theater of the age.

This propaganda was greeted alternately by the populace with surprise, applause, criticism, condemnation; slowly commendation and practical approval. This intellectual and humanitarian condition in Europe met with the already awakened conscience in America to the needs of the people. We can give but few of their leading actors. William Lloyd Garrison, whose mother had been a professional accoucheur in Baltimore, rearing and educating her sons after the mysterious disappearance of the father in their infancy. Henry Ward Beecher, Harriett Beecher Stowe, Lucy Stone Emerson, Lucretia Mott, the Channings, Emma Willard, Ann Preston, Emeline Cleveland and many noted Quakers, throughout the states. The "Brook Farm" experimenters, of whom a number had located in Cincinnati with Henry Ward Beecher as pastor; the Blackwell School, a leading educational center; these kindred spirits were in touch with the broadest outlook on life, and their system of underground telepathy kept them in touch with the highest ideals and criticisms of the world. It was quite possible in such an environment to develop a heroine for all time.

Elizabeth Blackwell, born in England in 1821, came to America with her parents and eight brothers and sisters in 1832. Her father died in 1838, leaving the family without financial inheritance, but a goodly stock of hereditary perseverance. Elizabeth was prepared as a teacher, specialized in music, with a goodly knowledge of Greek, Latin, history, mathematics, French and German. We find her in 1842 seriously considering the feasibility or possibility of removing opprobrium from women who in greater or less numbers were acting as "healers of the sick," although without scientific knowledge. Her many conferences with physicians of ability, friends of her family who believed in the necessity of women in the medical profession applauded, but without showing her the way. Like Daniel O'Connell she was ready to "Demand the utmost and to get something." First the money must be earned.

In 1845 we find her teaching music in Asheville, N. C., and reading medicine under Dr. John Dickson. After six months she removed to Charleston, S. C., continuing her instruction in music in a fashionable boarding-school for girls,

and here had increased opportunities for study under Dr. Samuel H. Dickson, a distinguished physician and professor in the Charleston Medical College.

June, 1847, we find her in Philadelphia continuing her studies in anatomy and midwifery with Dr. Allen and Dr. Warrington, who used their influence to broaden her acquaintance among noted members of the profession and college professors. Now began the effort for admittance to the best colleges, four in Philadelphia and one in New York City. The replies from the different faculties were cordial, the plan was possible, there was need of women physicians—but they could not be responsible in admitting women to their respective colleges.

It is said to be easy to find generals for a campaign, but harder to secure privates. As this record is but to sound the pean of victory in our profession, we merely state the fact that Elizabeth Blackwell in 1847 was both general and private in storming the medical fort. With personal application and skilled pen, with the influence of sympathizing friends, she continued to appeal to public opinion. Twelve smaller colleges were selected. A reply came from Dr. Charles E. Lee, dean of the faculty of Geneva Medical College, now a part of Syracuse University, who wrote: "Quorum of the faculty submitted your proposal to the class of students numbering 150. Their vote was unanimous for your admission, which also includes endorsement from the chairman of the class in a personal letter with an assurance of welcome." The two college sessions completed the medical course, and on Jan. 22, 1849, Miss Elizabeth Blackwell received the well-earned degree of Doctor of Medicine. Her proficiency was not surpassed by any of her fellow students, who also have made American history, and their loyalty continued throughout their lives.

The admission of a woman for the first time to complete medical education and full equality in the privileges and responsibility of the profession produced a wide-spread effect in America. The public press most generally recorded the event and expressed favorable opinion. The London *Punch* gives a poem, of which we quote only the first stanza:

"Not always is the warrior male
Nor masculine the sailor.
We all know Zonagassa's tale,
We've all heard 'Billy Taylor,'
But for a noble heroine, she
Who wore the palm of knowledge
And took a medical degree
By study at her college."

Dr. Blackwell realized that only the first step had been taken, and although politely received by the heads of the profession of Philadelphia as a professional sister, was welcomed to the clinics of Pennsylvania Hospital and made intern of Blackley Almshouse. As better opportunities were offered in England and France, her decision was made to profit by European study. In London she received cordial reception from noted physicians; in St. Thomas and other hospitals she was invited to clinics and operations, the latter in most instances performed without anesthetics, yet her teachers and best friends strongly urged that Paris was the best place for thorough study. After two months in the general hospitals of Paris we find her a matriculant of La Maternité—the most practical place for definite instruction in obstetrics and gynecology, Drill's clinics and ward work from morning until night, with no confusion, no pause and a comprehensive progress of each pupil was constantly listed by examination.

It was Dr. Blackwell's determination to become a skilled surgeon, but destiny decided otherwise. She contracted purulent ophthalmia from a patient and lost the sight of one eye, and incidentally much valuable time. At La Maternité, as in her previous medical work, she secured the highest credentials of her attainments and introduction to men of high standing in the profession. She returned to London. Application being made to the Dean of St. Bartholomew Hospital, the Medical Council decided that Miss Elizabeth Blackwell, a lady well connected in England and the United States, be admitted as student with permission to study in any ward, and follow the visit of any physician or surgeon who was willing to extend to her the facilities of his department. This permission was even accompanied by a cordial welcome from the Dean, Mr. James Paget, M.R.C.S., since, Sir James Paget. This, indeed, was joyful news to be admitted to the highest medical sanctuary, where every ward was open to her except the department for female diseases. In St. Bartholomew Hospital the admirable lectures on pathological anatomy by Sir James Paget; Dr. Kirk on physiology; Dr. Baley in his valuable investigation on dysentery, with courteous welcome to the wards of Drs. Stanley, Lawrence and Lloyd, the time passed pleasantly and profitably. Mrs. Paget introduced her as a "benefactor to the race," while Dr. Burrows, as having "established a principle for others by the success of her laudable enterprise"; and now, on the eve of her leaving for America, July, 1851, she might do anything she pleased at St. Bartholomew Hos-

pital. Were her friends prophets that they saw in vision the honor to be awarded this lovely, energetic worker for the good of the race, the success of which she saw firmly established? She but finished her personal work three years since, and her ideal has been the keynote for medical women and will be for all time.

It was with a conscientious purpose that Dr. Elizabeth Blackwell returned to America after six years of medical study, although opportunities of remunerative private practice were available in London. Her first public work after her return to New York City, where she had decided to establish herself, were "Lectures on Laws of Life in Regard to the Physical Education of Girls." These lectures were well received by her audience, and being published, gained an encouraging letter from Dean Charles E. Lee of Geneva Medical College, as well as valuable commendations from Mr. Ruskin.

In the two years of her absence in Europe there had been general skirmishing along medical lines in America. Her sister Emily had begun the study of medicine, was refused admission to the college honored by Dr. Elizabeth's brilliant record, yet was accepted at Cleveland College, where she graduated in 1852. In Boston a school of midwifery was started, but without patients. The Woman's Medical College of Pennsylvania received its charter in 1850, but also without clinical or hospital opportunities.

So far we have principally emphasized the "general's" work, but now we find in the field privates of caliber for majors, captains and sergeants. It was for the purpose of systematizing medical work among women and setting a world example of the necessity for and capabilities of women, could opportunities be created where opposition was less deeply seated than in older countries, that Dr. Blackwell returned to America.

In Boston Miss Harriett Hunt, after some years of study with private tutors, as then the general custom with men as well, applied for admission to Harvard. She was refused. Applying again in 1850, four out of seven members of the faculty voted aye. Three colored men applied at this time. The students rebelled and Miss Hunt's permission was withdrawn. However, she did continue studying as men had done before her, was patronized and before her twenty-fifth anniversary she received her "license to practice" as men had been qualified.

Michigan, too, had ambitious women. Margaret Cannon Osborn, a student at the young ladies' seminary at Zenia, Ohio, began the study of

medicine with Dr. Brown, one of the professors. Her marriage to Dr. Osborn in 1846 delayed her theoretical studies while she became the mother of ten children, of whom our honored Ex-Governor Chase Osborn is one. In 1860 she paid the government tax and obtained license—obtained by filing the affidavits of six freeholders that she had had ten years of practice of medicine. Still unsatisfied, we find this honorable woman special assistant of her husband and partner at the age of 68 taking the medical examination of the College of Physicians and Surgeons of Indianapolis, and receiving her long-coveted diploma. She continued in active practice in Indianapolis until 82 years of age, six years after the death of her illustrious husband, Dr. George A. Osborn, and is still interested in her profession and all public affairs, although 86 years old. With Dr. Margaret Cannon Osborn, whose gift of her son, Ex-Governor Osborn of Michigan, our subject has special interest.

It seems certain that woman's necessities desired women physicians in their midst, and there were some who had modestly acquired skill by private routes and were reaping financial benefits through the known education and success of Dr. Elizabeth and Emily Blackwell. They established the New York Infirmary for Women and Children in 1854, warmly supported by Rev. Henry Ward Beecher. Dr. Elde of Philadelphia and Rev. Dr. Tyng, Jr., consulting physicians, Dr. Valentine Mott, Drs. John Watson, Willard Parker and Isaac Taylor were the early medical friends of the infirmary and remained so through life. Dr. Elizabeth Blackwell, physician in chief, Dr. Emily Blackwell, surgeon, she having returned from two years' study in Europe, a portion of the time having been spent with Sir James Simpson, as his private assistant, Dr. Marie Kackrewska, resident physician. A word concerning this most marvelous woman shows how world-spread had become the determination for educated women physicians, centralizing the work in America. Dr. Schmitt, head of the Berlin midwifery department, discovered her talent, advised her to study and finally appointed her chief midwife in the hospital under him. There she taught classes of about 150 women and 50 men. When Dr. Schmitt died the American consul advised her to come to America, but here the German doctors wanted her to become a nurse. She obtained her medical degree in Cleveland in 1854. Her father was a German baron, but died leaving his family in destitute circumstances. The New York Infirmary was the first hospital where women could receive

practical instruction in America, except by personal favor. In 1862 the Woman's Hospital and Clinic was established in connection with the Woman's Medical College of Pennsylvania. The same year the New England Hospital for Women and Children was incorporated in Boston with Dr. Marie Zackrewska as resident physician.

The leading spirits of the Woman's Medical College of Philadelphia and Woman's Hospital were Dr. Ann Preston and Dr. Emeline H. Cleveland, an alumna of the W. M. C. of Pennsylvania and also of La Maternité of Paris. The latter was eulogized to his class in the University of Pennsylvania by Professor Wallace as the greatest obstetrician in America, not surpassed by Madame Boivin of Paris. From these three centers, New York, Boston and Philadelphia, work was extended. The alumnae, after completing college and hospital work, established other hospitals, as Dr. Mary Thompson in Chicago, Dr. Charlotte Blake Brown in San Francisco, the Women's Hospital in Minneapolis, Dr. Rachel Gleason, wife of Dr. Edward Gleason of Elmira, water-cure, an alumna of Syracuse University, who in this popular sanatorium for wealthy, chronic invalids won many people of influence to the cause, as well as recruits to the profession. Women physicians were not content with work at home but must needs carry the message to foreign lands.

Dr. Clara Swain, the first woman medical missionary, located in China and blazed the trail for others to follow. It is of interest that the first class of women graduates in medicine numbered eight, while the first class of men, one hundred years previously, had but a single member. Of the several medical colleges established for women before the state universities realized that education was useful to women, the Woman's Medical College of Pennsylvania is the one which still finds a reason for its existence. The New York Infirmary Medical College is incorporated with Cornell University; the Chicago Woman's Medical with the College of Physicians and Surgeons; the New England Medical ceased to exist in 1872.

Through the generosity of Miss Mary Garrett Baldwin, who donated \$100,000 as a fund toward Johns Hopkins University, it is to be maintained for all time equally for women as men.

We find the first qualified woman physician in Grand Rapids, Mich., in 1868; the second, M. L. Towsly, M.D., in Kalamazoo in 1869. In 1870 Grand Rapids led the world in appointing a woman city physician, with double the salary of her predecessor. The office was tendered her the second year, when it became necessary for her

to remind the aldermen that their recently revised charter read "no one but an elector shall hold office," which is still the law.

The State Medical Society met in Grand Rapids in June, 1872, and so far as possible every medical woman in the state was notified. But three responded, Dr. Ruth Geary, Ypsilanti, Dr. Sibelia F. Baker of Coldwater and Dr. Frances A. Rutherford of Grand Rapids, who were elected members of the society by acclamation, the first women so honored—although the same year Dr. Anita Tyng of Rhode Island and Dr. Frances Porter of Kansas were so honored a few months later by their respective state societies. It was natural Michigan should lead other states in opening wide the doors of her university to all seekers of knowledge in 1871.

There is a legend that Mrs. Ruth Geary some years before asked under what condition she could receive instruction from the able men to whose support she contributed. Dean Palmer replied: "Women can only be admitted here as visitors." Day after day as Dr. Palmer met her with the question, "What are you doing here?" her invariable reply, "Just visiting," continued for the whole session. It must have been with real enthusiasm in later years that Ruth Geary, M.D., in company with her talented daughter, Harriet Geary, drank of the fountain of knowledge without question. Harriet Geary was the first woman graduate from the medical department of the U. of M. who performed a laparotomy; she bid fair to surpass competitors in surgery, but early succumbed to tuberculosis, and we have but the memory of—might have been. With the last commencement of the U. of M. the women medical graduates number 440, and, as the first American Alumnae invaded other states and countries, so should the university have recorded its honor roll.

Dean Victor C. Vaughan, president-elect of the American Medical Association, in a personal letter, says, "I can say with certainty that the portion of success among women has been as great as that among men."

Just here pardon a few statistics from the Department of Commerce received to-day. I notice that the census for 1910 is not yet completed, but gives the number for 1900 as 124,615 male physicians and 4,083 females. There are at present 8,000 medical women who claim America as their home; two-thirds of this number are married, have children, and a carefully compiled record shows that less than 6 per cent. die before the fifth year.

Of the earlier alumnae of Michigan University, Emma Call, class of 1873, not only led the class

of ninety-six, of whom twelve were women, but carried off three honors as well. After two years of study in Europe, she returned to Boston, became identified with Dr. Marie Zackrewska and Dr. Mary A. Smith in the New England Hospital for Women.

Dr. Eliza Moshier, ex-dean of women at U. of M., and a writer; Lenora Howard, a resident of Grand Rapids, class of 1876, reached Pekin in June of the following year and began her work as missionary. During the autumn of 1878, the Viceroy, Li Hung Chang, sent for her to come to Tientsin to attend his wife. She was entertained at the official residence. Lady Li recovered. Li Hung Chang was so favorably disposed toward western science that he had taken a heathen temple built in honor of his predecessors and converted it into a hospital to be devoted distinctly to Christian work under the charge of a London missionary. In gratitude for the restoration of Lady Li he defrayed the expenses of a woman's ward in the hospital under the direction of Dr. Leonardo Howard. Dr. Howard made her residence in the foreign settlement about three miles from the temple and opened a dispensary there also. She cared for Li Hung Chang's mother in her last illness, who left \$1,000 for the hospital, the first legacy of a Chinese woman for Christian benevolence. During Gen. U. S. Grant's visit to China, she acted as his interpreter. In 1887 Lady Li built a new hospital for Dr. Howard.

Dr. Minnie St. Clair Headland was physician to the Empress Dowager of China. The women of the U. of M. must be responsible for the reply of Li Hung Chang when asked what he most feared from the western nations: "I do not fear your armies, nor your navies, nor your diplomats, but I do fear your medical women."

Michigan, as early as 1885—following the example of New York, Massachusetts, Pennsylvania and some other states—employed a woman physician, Helen Bissell, M.D., in the state asylum in Kalamazoo. Other women physicians were employed after this date, and in 1901 the legislature passed in substance: "All institutions where women and children are detained and kept shall employ women physicians"—really taking the lead of other states in not only providing for the state insane asylums, but for all private institutions as well.

Chicago with its five hundred ethical women physicians and hospitals has appealed to U. of M. women; in surgery, Dr. Bertha Van Housen and Dr. Alexander; in scientific work, Dr. Lydia Dewitt and Dr. Alice Hamilton. Of especial

interest is the public health work among women which Dr. Eleanor G. Eberhard has so successfully continued, following Dr. Rosalee S. Morton, its first chairman.

"In the words of the public there is no reason why the medical profession should discriminate against men in the matter of education; practically it has not been possible to do so, and we suggest Public Health Education."

Quite natural as the Woman's Medical College of New York Infirmary was the first college to have a full professorship in hygiene and public health, so Lucy Eames of Muskegon, bacteriologist to Hackley Hospital and medical inspector of schools, is adding to her home work by telling other educators how to make medical inspection most practical.

We refrain from giving further personal record of individuals, but could emphasize some special success of each of the 141 located in Michigan. In Detroit, Kalamazoo, Ann Arbor, Jackson, Adrian, Manistee, Saginaw, Lansing, Grand Rapids and other cities and towns within the state a fair proportion of the sick seek advice from women.

This paper is but a suggestion of the work fairly begun, and opportunities, for the test is not, "is it a man or woman?" but the test of real ability, education, tact and perserverance, for now as never before in all history do conditions warrant the work of men and women together for the betterment and welfare of humanity. To paraphrase a recent Fourth of July speech: "More and more are men and women's minds turning to the hope of success through their own efficiency, rather than through the deficiency of others."

REFERENCES

- Pioneer Work in Opening the Medical Profession to Women, by Elizabeth Blackwell, M.D.
 Woman's Work in Medicine in America, by Mary Putnam Jacobs.
 Recent Reports from Women's Hospitals in Philadelphia, New York, Boston, Chicago and San Francisco.

CLINICAL CASE REPORTS

PRIMARY SYPHILIS AT AGE OF 81

R. A. C. WOLLENBERG, M.D.

DETROIT

During my recent service in the skin clinic of St. Mary's Hospital, there appeared a case of primary and secondary syphilis which was unique in respect of the age of the patient.

Wm. H., aged 81 years and 10 months, Canadian, had come to Detroit six months previously to spend here the days of his decline. He stated that he had been a sober and industrious farmer all his life time, and that after the death of his wife, thirty-nine years before, he had had no sexual connection to the date of his falling a victim to the wiles of the insistent mistress of his boarding house, a woman about 40 years of age. This occurred two months before his visit to the clinic. Two weeks after the connection he was aware of an erosion of the foreskin, which would not heal under his self-medication and caused him to seek advice.

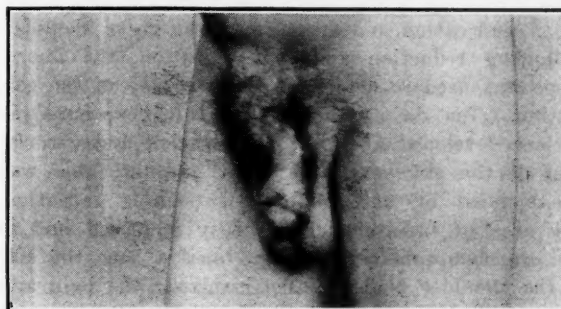


Fig. 1

The patient was a "gnarled old oak," but, though still moderately robust, showed every evidence of senility, as, dry wrinkled skin, white hair, flabby muscles, arcus senilis, and sclerotic temporal and radial arteries. He appeared without question to have the age he claimed. There was discovered a maculopapular eruption of skin of trunk and limbs, general enlargement of the lymphatic glands, and mucous patches of tongue and throat. The prepuce was edematous, and its dorsal edge was the seat of a large "beef-steak" chancre. He had also a large right inguinal hernia which had existed for many years.

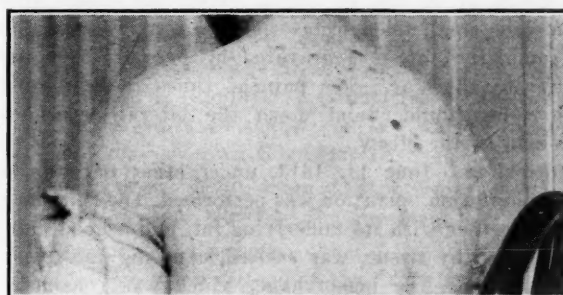


Fig. 2

After two visits to the clinic the patient did not return, and I have lately learned that he was dead as result of an attack of pneumonia.

The sexual virility of this man was a most unusual one, and a venereal infection at his late age has never been reported in modern medical history, so far as I know.

Accompanying photographs show the chancre and skin lesions.

J. Henry Smith Building.

SKIN GRAFT FOR X-RAY DERMATITIS

J. J. FABIAN, M.D.

GRAND RAPIDS, MICH.

The chronicity, severity of pain, constitutional symptoms and instantaneous relief following transplantation, justifies me in reporting the following case:

Mrs. H. E. H., married, aged 62, family history negative, has four healthy children. With the exception of "malarial fever" patient has always been in good health up to five years ago, when she fell, suffering a dislocation and fracture of the right shoulder. Following reduction and immobilization, the fluoroscope was used to determine the accuracy of the correction. Ten days following the third exposure the patient developed a slight inflammation and excoriation of the skin over the right scapula; this was accompanied by an itching and burning sensation. The area of involvement gradually increased in size and the symptoms in severity, until a zone the size of the shoulder blade became involved; the pain and discomfort became constant, requiring the use of opiates for their relief.

For the past three or four years conditions have remained much the same, excepting that the patient developed a marked neurasthenia, at times bordering on melancholia. During all this time she had been under treatment, traveling from one physician to another, seeking relief.

Physical Examination. Patient is emaciated and appears older than the age given. Lungs, few crepitant râles at right base posteriorly; heart, negative; kidneys, trace of albumin and few granular casts; pulse, 110; temperature, 101; blood, negative. Examination of the skin over the right scapula shows a thickened, dark-colored, oval scar measuring 13 cm. in width by 17 cm. in length. Over the entire area numerous small telangiectases can be seen. Pain, which is complained of, is aggravated by pressure over the center of the scar. The pain at times radiates over the right shoulder and down the lateral aspect of the arm to the elbow.

Operation. June 14, 1913, under ether narcosis, a transplantation operation was performed. The thickened scar, together with its underlying fat, and a good margin of healthy tissue, was excised, exposing the trapezius muscle. The hemorrhage, which was considerable, was controlled by means of ligature and hot compresses. From the lateral surface of the right thigh, previously made sterile, medium-sized Thiersch grafts were removed with a razor, transferring them directly to the wound. It was not thought advisable to attempt extensive transplanting at one sitting, so the area was left incompletely filled, to be completed at a second operation. The usual rubber tissue strips and wet dressings were applied; these were left on for twenty-four hours, at which time it was seen that every graft was nicely taking. We then left the area exposed to the air and protected by a wire cage. This was kept in place for seven days and the numerous crusts which had formed were removed by vaseline dressing applied for twenty-four hours. On July 2 the second opera-

tion was performed and the balance of the exposed area was filled in with isodermic grafts taken from the thigh of the patient's daughter. These grafts were left exposed to the air without dressings and had all taken after five days. Patient dismissed July 10, cured.

The remarkable feature in this case was the absolute relief afforded by the removal of the extensive scar, the success of each graft on a freshly exposed surface, both autodermic and isodermic, and the general improvement in the health of the patient.

The grafts, if they are to live, become adherent to the underlying structure within a few minutes after they are applied, thus the surface from which a graft is removed, after overlaying it for ten minutes, is seen to be freshly oozing. The open dressing or exposure to air as advised by Wiener,¹ with proper protection against injury or dirt, should be the method of choice. After grafts have become well imbedded and crusts have formed between them, a vaseline ointment dressing for twenty-four hours will effectually clean up the entire field. The operation is necessarily an aseptic one—no antiseptics being used—and considerable care should be exercised in laying on the grafts without the slightest injury. A general anesthetic should always be used in removing the skin, gas being the anesthetic of choice.

"DON'T DIE ON THIRD"

All the world's a baseball diamond. Every physician and surgeon is in the game—the dead ones are looking on. Perhaps you have reached first by your own efforts. It may be that the sacrifices of your friends have enabled you to reach second. Then on some one's "long fly" you have advanced to third. The competition against you at third is stronger than at first or second. Your competitors converge all their attention on you, scheming to "put you out" or put you among the "left on bases" in the box score of the game. Keep your eyes wide open. Don't die on third.

Are you doing your best to win the score that life is ready to mark up against your name? Third base has no laurels upon which you can rest. What are you doing on third? If you place all your dependence on what is coming to you, your waiting means failure. What are you doing on third? Waiting for "something to turn up"? Don't—nothing turns up but the thumbs of the men who are watching you from positions higher than yours, they may turn down.

So don't die on third. Bring to third every bit of your honest strength; study conditions, dig your spikes into the soil and get ready to run; postpone thinking of your success and yearly profits until you hear the umpire call "Safe at Home."—*The Rotarian*.

1. Journal of the Am. Med. Ass'n, Vol. XL, No. 20.

FORTY-EIGHTH ANNUAL MEETING OF THE MICHIGAN STATE MEDICAL SOCIETY, FLINT, MICH., SEPT. 4 and 5, 1913

OFFICIAL CALL

The Forty-Eighth Annual Meeting of the Michigan State Medical Society will be held in Flint, Genesee County, Michigan, on Thursday and Friday, September 4 and 5, 1913. The Fifth Annual Meeting of the County Secretaries' Association will be held on Wednesday afternoon, September 3, at 3 p. m. The Council will meet in regular session on Wednesday evening, September 3, at 8 o'clock.

WALTER H. SAWYER, President.

FREDERICK C. WARNSHUIS, Secretary.

PLACE OF MEETING

The General Session, the House of Delegates and all Scientific Sessions will meet in the Masonic Temple. The exhibitions will also be located in this building. The County Secretaries' Association will meet in the Masonic Temple at 3 p. m., September 3. The first session of the Council will be held in the parlor of the Hotel Dresden Wednesday evening, September 3, at 8 p. m.

THE COUNCIL

Chairman, William T. Dodge, Big Rapids.

Vice-Chairman, A. E. Bulson, Jackson.

Secretary, Frederick C. Warnshuis, Grand Rapids.

Meetings

Wednesday, September 3, at 8 p. m.

Thursday, September 4, at 12 m.

Friday, September 5, at 12 m.

HOUSE OF DELEGATES

Masonic Temple.

President, Walter H. Sawyer, Hillsdale.

Secretary, Frederick C. Warnshuis, Grand Rapids.

By-Laws—Chapter IV, Section 1. Each component county society shall be entitled to send to the House of Delegates each year one delegate and one alternate for every fifty members, and one delegate for each major fraction thereof; but each county society holding a charter from this society, which has made its annual report as provided in the Constitution and By-Laws, shall be entitled to one delegate and one alternate.

First Session, Thursday, September 4th

8:00 A. M.

Order of business:

1. Call to order by the President.
2. Report of Committee on Credentials.
3. Roll Call.
4. Reading of the minutes of the last Annual Meeting.
5. Report of the Council.

W. T. Dodge, Big Rapids, Chairman.

6. Report of the Committee on Legislation and Public Policy.

E. T. Abrams, Dollar Bay, Chairman.

7. Report of the Committee on Fee-Splitting.

C. B. Stockwell, Port Huron, Chairman.

8. Report of the Committee on Public Health Education.

Frances Rutherford, Grand Rapids, Chairman.

9. Report of the Committee on the Study and Prevention of Tuberculosis.

Collins H. Johnston, Grand Rapids, Chairman.

10. Report of the Committee to Encourage the Systematic Examination of the Eyes and Ears of Schoolchildren Throughout the State.

Walter R. Parker, Detroit, Chairman.

11. Report of the Committee on Medical Education.

David Inglis, Detroit, Chairman.

12. Report of the Committee on Venereal Prophylaxis.

A. P. Biddle, Detroit, Chairman.

13. Report of the Delegates to the American Medical Association.

E. T. Abrams, Dollar Bay, Chairman.

14. Report of the Committee on Specialties.

Emil Amberg, Detroit, Chairman.

15. Election of Committee on Nominations.

The duty of this committee is to nominate:

- (a) 1st, 2d, 3d and 4th Vice-Presidents.
- (b) To nominate one delegate and one alternate delegate to the House of Delegates of the American Medical Association to succeed E. T. Abrams, whose term expires.
- (c) To nominate Councilors for the 2d, 8th, 9th and 12th districts.
- (d) To fix the place of meeting for 1914.

By-Laws—Chapter VI, Section 2. The House of Delegates shall elect annually, at its first meeting, a Nominating Committee of five from the House of Delegates; no two of whom shall be from the same Councilor District.

16. Appointment of Business Committee and other working committees by the President.

17. Miscellaneous Business.

(a) Recommendations of the Council.

(b) Proposal of amendments to the Constitution and By-Laws.

AMENDMENTS TO BY-LAWS

In compliance with the instructions of the Council the following amendment to the By-Laws is offered:

Chapter IX, Section 10:

Strike out the word "June" and insert in its stead "April"; the sentence to read: "Members in arrears after April 1 shall not be entitled to defense for any suit, the cause of action of which arose while in arrears, and any member sued or threatened before joining the society, or before the organization of the Medico-Legal Fund, must pay the actual cost of defense in such suit."

By-Laws—Chapter XI, Section 1:

Add to the section: "Such dues and assessment shall be remitted to the secretary of the State Society on or before April 1 of each year."

Chapter XI, Section 2:

Strike out: "On the date above stated," and insert: "On or before April 1 of each year."

18. New Business.

19. Adjournment to the General Session.

Second Session, Friday, September 5th
8:00 A. M.

1. Roll Call.
 2. Reading of Minutes of Previous Session.
 3. Report of Business Committee.
 4. Reports of Appointed Committees.
 5. Report of the Committee on Nominations.
 6. Election of Officers.
 7. Unfinished Business.
 8. Miscellaneous Business.
- Adjournment to Section Meetings.

HOUSE OF DELEGATES.—DELEGATES AND ALTERNATES TO THE FORTY-EIGHTH ANNUAL MEETING

Note.—The black-face type is that of the delegate; the other that of the alternate.

ALPENA—Branch No. 46

C. M. Williams, Alpena.
D. A. Cameron, Alpena.

ANTRIM—Branch No. 65

(One delegate.)

BARRY—Branch No. 26

(One delegate.)

BAY—Branch No. 4

J. W. Gustin, Bay City.
J. C. Grosjean, Bay City.

BENZIE—Branch No. 59

G. O. Edmunds, Honor.
E. J. C. Ellis, Benzonia.

BERRIEN—Branch No. 50

L. A. King, Baroda.
R. C. Allen, St. Joseph.

BRANCH—Branch No. 9

A. G. Holbrook, Coldwater.
W. A. Griffith, Coldwater.

CALHOUN—Branch No. 1

R. D. Sleight, Battle Creek.
W. H. Haughey, Battle Creek.

CASS—Branch No. 36

Edgar A. Planc, Union.
Wm. C. McCutcheon, Cassopolis.

CHARLEVOIX—Branch No. 37

(One delegate.)

CHEBOYGAN—Branch No. 58

Chas. B. Tweedale, Cheboygan.

CHIPPEWA—Branch No. 35

James J. Lyon, Sault Ste. Marie.
J. A. Ferguson, Rudyard.

CLINTON—Branch No. 39

M. Weller, St. Johns.
J. E. Taylor, Ovid.

DELTA—Branch No. 38

M. P. Fenelon, Escanaba.
A. L. Laing, Escanaba.

DICKINSON - IRON—Branch No. 56

(One delegate.)

EATON—Branch No. 10

W. H. Rand, Charlotte.
A. H. Burleson, Olivet.

EMMET—Branch No. 41

J. H. Charters, Boyne City.
J. J. Reycraft, Petoskey.

GENESEE—Branch No. 24

A. J. McReynolds, Flint.
W. J. Wall, Avoca.
Henry Cook, Flint.
H. D. Knapp, Flint.

GOGEBIC—Branch No. 52

L. O. Houghten, Ironwood.
E. Madajesky, Bessemer.

GRAND TRAVERSE - LEELANAU—Branch No. 18

(One delegate.)

GRATIOT—Branch No. 25

W. M. Drake, Breckenridge.
L. A. Howe, Breckenridge.

HILLSDALE—Branch No. 3

T. H. E. Bell, Reading.
C. T. Bower, Hillsdale.

HOUGHTON—Branch No. 7

(One delegate.)

HURON—Branch No. 47

Sheldon B. Young, Caseville.
E. E. E. Yale, Pigeon.

INGHAM—Branch No. 40

B. M. Davey, Lansing.
Seth Jones, Lansing.

IONIA—Branch No. 16

J. J. McCann, Ionia.
E. W. Lytle, Belding.

ISABELLA - CLARE—Branch No. 54

C. M. Baskerville, Mt. Pleasant.
S. E. Gardiner, Mt. Pleasant.

JACKSON—Branch No. 27

Peter Hyndman, Jackson.
C. D. Munro, Jackson.

KALAMAZOO—Branch No. 64

G. F. Inch, Kalamazoo.
A. I. Noble, Kalamazoo.
C. H. McKain, Vicksburg.
H. Ostrander, Kalamazoo.
E. P. Wilbur, Kalamazoo.
W. F. Hoyt, Paw Paw.

KENT—Branch No. 49

N. M. Kassabian, Coopersville.
J. D. Brook, Grandville.
B. R. Corbus, Grand Rapids.
F. J. Lee, Grand Rapids.
Collins H. Johnston, Grand Rapids.
T. C. Irwin, Grand Rapids.

LAPEER—Branch No. 23

Peter Stewart, Hadley.
J. P. Eggleston, Imlay City.

LENAWEE—Branch No. 51

W. B. Sprague, Palmyra.
R. E. Eccles, Blissfield.

LIVINGSTON—Branch No. 6

R. H. Baird, Howell.
C. E. Skinner, Howell.

MACOMB—Branch No. 48

H. F. Taylor, Mt. Clemens.
E. G. Folsom, Mt. Clemens.

MANISTEE—Branch No. 19

James A. King, Manistee.
R. J. Kirkland, Manistee.

MARQUETTE - ALGER—Branch No. 28

A. W. Hornbogen, Marquette.
T. A. Felch, Ishpeming.

MASON—Branch No. 17

W. C. Martin, Scottville.
W. Heysett, Ludington.

MECOSTA—Branch No. 8

George H. Lynch, Big Rapids.
A. A. Spoor, Big Rapids.

MENOMINEE—Branch No. 55

R. G. Marriner, Menominee.
Edward Sawbridge, Stephenson.

MIDLAND—Branch No. 43

F. A. Towsley, Midland.

MONROE—Branch No. 15

V. Sisung, Monroe.
W. F. Acker, Monroe.

MONTCALM—Branch No. 13

M. E. Danforth, Stanton.
F. A. Johnson, Greenville.

MUSKEGON - OCEANA—Branch No. 61

F. B. Marshall, Muskegon.
George S. Williams, Muskegon.

NEWAYGO—Branch No. 60

N. De Haas, Fremont.
Willis Geerlings, Reeman.

OAKLAND—Branch No. 5

George McKinnon, Oxford.
H. A. Sibley, Pontiac.

O. M. C. O. R. O.—Branch No. 11

C. C. Curnalia, Roscommon.
L. A. Harris, Gaylord.

ONTONAGON—Branch No. 66

(One delegate.)

OSCEOLA - LAKE—Branch No. 30

H. L. Foster, Reed City.
A. Holm, Leroy.

OTTAWA—Branch No. 32

(One delegate.)

PRESQUE ISLE—Branch No. 63

B. G. Larke, Rogers City.
W. W. Arscott, Rogers City.

SAGINAW—Branch No. 14

G. H. Ferguson, Saginaw.
D. E. Bagshaw, Saginaw.

SANILAC—Branch No. 20

James A. Fraser, Lexington.
James W. Scott, Sandusky.

SCHOOLCRAFT—Branch No. 57

Andrew Nelson, Manistique.
S. H. Rutledge, Manistique.

SHIAWASSEE—Branch No. 33

George P. Sackrider, Owosso.
A. M. Hume, Owosso.

ST. CLAIR—Branch No. 45

George S. Ney, Port Huron.
M. E. Vrooman, Port Huron.

ST. JOSEPH—Branch No. 29

J. H. Moe, Sturgis.
R. D. Runyan, Sturgis.

TRI-COUNTY—Branch No. 62

O. L. Ricker, Cadillac.
W. J. Smith, Cadillac.

TUSCOLA—Branch No. 44

H. A. Bishop, Millington.
H. S. Karr, Akron.

WASHTENAW—Branch No. 42

J. A. Wessinger, Ann Arbor.
John W. Keating, Ann Arbor.
Wm. Blair, Ann Arbor.
R. Bishop Canfield, Ann Arbor.

WAYNE—Branch No. 2

J. W. Vaughan, Detroit.
Guy L. Kiefer, Detroit.
Walter Ford, Detroit.
F. B. Walker, Detroit.
J. E. King, Detroit.
E. W. Haass, Detroit.
W. J. Wilson, Jr., Detroit.
J. Stanley Miner, Detroit.
A. N. Collins, Detroit.
Hugo A. Freund, Detroit.
A. D. Holmes, Detroit.
F. B. Robbins, Detroit.
Ray Connor, Detroit.
L. J. Hirschman, Detroit.
Angus McLean, Detroit.
Howard Loongyear, Detroit.
R. E. Jamieson, Detroit.
R. L. Clark, Detroit.
H. W. Hewett, Detroit.
C. G. Jennings, Detroit.

GENERAL MEETING

Thursday, September 4th

10 A. M.

Masonic Temple Auditorium.

President—Walter H. Sawyer, Hillsdale.

Secretary—Frederick C. Warnshuis, Grand Rapids.

1. Call to order by the President.
2. Invocation.
3. Address of Welcome by C. S. Mott, Mayor.
4. Address of Welcome by Noah Bates, President Genessee County Society.
5. Response on Behalf of State Society by Walter H. Sawyer, President.
6. Report of the Committee on Arrangements.
H. E. Randall, Flint.
7. Report of the House of Delegates by the Secretary.
8. Annual Address of the President, "District Supervision of Public Health."

Walter H. Sawyer, Hillsdale.

Dr. Sawyer's paper will be discussed by the following:

Rt. Rev. John Newton McCormick, Grand Rapids.
Hon. Perry F. Powers, Cadillac.
Hon. Milo D. Campbell, Coldwater.
Judge Claudius Grant, Detroit.
Prof. Wm. C. Hoad, Ann Arbor.
Rt. Rev. Charles D. Williams, Marquette.
United States Senator Wm. Alden Smith, Grand Rapids.

9. Address, Woodbridge N. Ferris, Governor, State of Michigan.
10. Miscellaneous Business. Under this head there will be a general discussion of questions of medical economics. The opportunity is presented to every member to bring before the entire Society any subject of general interest, either by informal discussion or formal resolution.

Nominations for President for 1913-1914.

Adjournment.

SECOND GENERAL MEETING

Friday, September 5th

11:30 A. M.

1. Reading of Minutes.
2. Unfinished Business.
3. Report from the House of Delegates.
4. Miscellaneous Business. Another opportunity is given to present to the attention of the general body questions of general interest.
5. Announcement of the Committee on Nominations of the result of the ballot for President.
6. Introduction and Installation of the President-elect.
7. Resolutions.
8. Adjournment *sine die*.

SCIENTIFIC SECTIONS MEETINGS

By-Laws—Chapter III, Section 3. Except by special vote the order of exercises, papers and discussions as set forth in the official program shall be followed from day to day until it has been completed. No paper shall be read by title nor read by any other

person than its author, except as a result of sickness of the author, or by the unanimous vote of the Section to which it belongs.

Sec. 4. No address or paper before the Society, except that of the President, shall occupy more than fifteen minutes in its delivery; and no member shall speak more than five minutes or more than once on any subject.

Sec. 5. All papers read before the Society shall be its property. Each paper read shall be immediately deposited with the Secretary of the Section.

SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY

Chairman—Eugene Smith, Detroit.

Secretary—H. Beach Morse, Bay City.

(As soon as a paper has been read it is to be filed with the secretary.)

First Session, Thursday Afternoon, September 4th

1:45 P. M.

1. Chairman's Address. EUGENE SMITH, Detroit.
2. Paper, "Some Points in the Technic of Sub-mucous Resection." C. H. BAKER, Bay City.
3. "Injuries to the Head and Ear Disturbances." EMIL AMBERG, Detroit.

Synopsis.—The close connection between injury to the head and disturbances of the ear is far greater than is generally accepted.

A more careful observation will, undoubtedly, bear out this assertion. It is not correct to assume that a sudden deafness, after an injury to the head, is due to a preexisting chronic middle ear catarrh.

4. "Report of Seventy-Five Cataract Extractions." D. EMMETT WELSH, Grand Rapids.

5. Paper, "Catarrhal Deafness. A New Explanation and Treatment."

WILFRID HAUGHEY, Battle Creek.

Synopsis.—A consideration of deafness and of the pathology of Parnacusis Willisii, with a newly suggested explanation and treatment based on this explanation. Report of two cases showing marked improvement in hearing.

Second Session, Friday Morning, September 5th

9:00 A. M.

6. "Acute Pharyngitis." B. N. COLVER, Battle Creek.
7. Paper, "Temperature Changes in Mastoiditis." DON M. CAMPBELL, Detroit.

Synopsis.—General consideration of temperature in septic conditions, and especially with reference to variations in septic mastoiditis. Case reports and exhibition of charts.

8. "Personal Experience with the Sub-mucous Operation." ANNA O'DELL, Detroit.

Adjournment to the General Session at 11:30 a. m.

Third Session, Friday Afternoon, September 5th

1:45 P. M.

Election of officers.

9. "The Care and Treatment of Deep and Superficial Injuries of the Eyeball."

C. L. CHAMBERS, Detroit.

10. "Trephine Operations in the Treatment of Glaucoma." WALTER H. PARKER, Detroit.
11. "The Relation of Ocular Symptoms to Remote Disorders." P. J. LIVINGSTON, Detroit.
12. Paper, "Mastoiditis." EDWARD J. BERNSTEIN, Kalamazoo.
13. Paper, "Cervical Lymphangitis Simulating Otitis Media." LOUIS J. GOUX, Detroit.

SECTION ON GENERAL MEDICINE

Chairman—James Cleland, Jr., Detroit.
Secretary—Benj. A. Shepard, Kalamazoo.

First Session, Thursday Afternoon, September 4th

1:45 P. M.

(The Secretary of the Section will collect all papers as soon as they are read.)

1. Chairman's Address.

JAMES CLELAND, Jr., Detroit.

2. "The Attitude of the General Practitioner Toward the Tuberculosis Problem."

J. B. JACKSON, Kalamazoo.

Synopsis.—Effort to check spread of tuberculosis most seriously hampered by lack of aggressive cooperation by large numbers of the medical profession. Many physicians unwilling to diagnose tuberculosis. The fact that the disease is curable is not fully appreciated by the profession. An aggressive policy includes: Early diagnosis, searching for sources of infection, recognizing house and room infections, chronic carriers, and the spreading of the teaching of the curability of the disease.

3. "The Diagnosis and Treatment of Tuberculosis. Lantern Slide Demonstration."

O. W. McMICHAEL, Chicago.

4. "The X-Ray Diagnosis of Diseases of the Lungs. Lantern Slide Demonstration."

A. W. CRANE, Kalamazoo.

Synopsis.—A large fluorescent screen gives a moving picture image of the living chest. Auscultation may be performed simultaneously. Plates are required for detail observations. Pulmonary tuberculosis as a rule begins in the hilum of the lung, an area relatively inaccessible to clinical examination. The x-ray translates all physical signs into terms of density and motion. Skill in roentgenology as in auscultation and percussion consists in the ability to interpret the signs.

Second Session, Friday Morning, September 5th

9:00 A. M.

5. "Spasmophilia."

COLLINS H. JOHNSTON, Grand Rapids.

Synopsis.—Spasmophilia is a functional disturbance of the nervous system, a condition met with in early childhood, which is recognizable through mechanical and galvanic hyperexcitability of the peripheral nerves and an inclination to tonic and clonic spasms, such as gen-

eral convulsions, laryngospasms, spasmodic apnea and tetany. It is a very frequent disease in early childhood.

It includes not only the greater part of the convulsions of childhood, but exists in a large number of apparently healthy children for weeks and months without attracting the attention of parents or physician by the manifestation of severe symptoms.

It is most frequently met with in the winter and spring, when it is found, according to some authorities, in 40 or 50 per cent. of artificially fed babies. It is rarely seen in breast-fed babies.

Spasmophilia is frequently inherited. The disease rarely begins before the fourth month of life and is seldom seen after the second year. It is frequently found in combination with rickets.

The treatment is partly dietetic and partly medicinal and is usually productive of prompt results.

6. "The Present Status of Salvarsan in the Treatment of Syphilis."

H. R. VARNEY and R. C. JAMIESON, Detroit.

Synopsis.—Advances made in the treatment of syphilis since the advent of salvarsan. Comparison of salvarsan, neosalvarsan and mercury in regard to properties, method of preparation, administration and effects. Rate of absorption and elimination of the different preparations. Indications and contra-indications of salvarsan. Advantages and disadvantages of this method. Conclusions.

7. Paper, "The Hypochlorite Treatment of Drinking Water; Observations and Conclusions Reached at the South Haven Station."

FRANK C. PENOYAR, South Haven.

8. "Nervousness in Children."

THEOPHIL KLINGMAN, Ann Arbor.

Synopsis.—Signs of neuropathic constitution, neuropathic physiognomy, mental status and motor sphere, diagnostic significance of paradox, perversity, timidity, weariness, inanition, physical fatigue, pavor nocturnus, idiosyncrosis, general motor restlessness, disturbance of sleep, tremors, etc. Nervousness and education.

9. "The Need of a Differential Diagnosis of Type of Diphtheritic Bacillus in the Management of the Disease."

BLANCH EPLER, Kalamazoo.

Synopsis.—Cases directing attention to the need of investigating the present status of the etiology of diphtheria. Importance and difficulty in determining a positive bacteriological diagnosis of virulent diphtheria bacilli, virulent pseudo-diphtheria bacilli and avirulent diphtheria. Methods of differentiation, prophylaxis and methods of hastening the disappearance of the organisms. Inadequacy of health departments. Quarantine. The practical benefits to be obtained by differentiation between harmless and harmful bacilli and by cooperation of bacteriologist and practitioner.

Adjournment to General Session.

Third Session, Friday Afternoon, September 5th

1:45 P. M.

Election of officers of Section for coming year.

10. "Irregularities of the Heart, with Special Reference to Heart Block."

MARTIN A. MORTENSON, Battle Creek.

Synopsis.—Short discussion of our knowledge of cardiac irregularities, history of heart block, with report of a very pronounced case with autopsy findings.

11. "Presentation and Discussion of Specimens Illustrating Endocarditis Caused by Streptococcus Viridans and the Streptococcus Rheumaticus and Points of Difference in their Clinical Manifestations. ROBERT H. BABCOCK, Chicago.

Synopsis.—Demonstration and discussion of specimens, pathologic differences in the different bacterial infections. Explanation of cause of fatality. Illustrative cases cited. Atrium of infection often the throat. Need of recognizing diseased tonsils as sources of danger to persons with valvular lesions. Clinical phenomena.

12. "Significance of the Aldehyd Reaction in the Urine."

J. B. WHINERY, Grand Rapids.

Synopsis.—Theory in regard to the change of the bile pigment in the intestinal tract and again in the liver. Disturbance of liver function resulting in the presence of aldehyd in the urine. Value of the reaction as an aid in diagnosis.

13. "Fever and Its Significance as a Symptom."

J. H. DEMPSTER, Detroit.

SECTION ON GYNECOLOGY AND OBSTETRICS

Chairman, Ernest K. Cullen, Detroit.

Secretary, Walter Manton, Detroit.

(The secretary will collect all papers as soon as they are read.)

First Session, Thursday Afternoon, September 4th

1:45 P. M.

1. "Early Diagnosis of Uterine Cancer."

J. H. CARSTENS, Detroit.

2. "Uterine Myomata and Malignant Degeneration."

W. P. MANTON, Detroit.

Synopsis.—A more intimate knowledge of uterine myomata shows that they are not the innocent growths formerly supposed. A very considerable number undergo malignant process inimical to the host. Prophylaxis or prevention does not consist in the removal of existing cancer, but in anticipating its occurrence through appropriate treatment. When myomata are single or small, myomectomy may be resorted to. When they are multiple or occupy the greater portion of the uterus, total ablation of that organ should be the operation of choice. This is imperative in the light of the increasing number of reports of malignant recurrence in the cervical stump, following supravaginal

hysterectomy in cases in which malignancy of the original growth had not been suspected. Report of an unusual and illuminating case.

3. "Calcification of Uterine Fibroids."

R. E. BALCH, Kalamazoo.

Report of case with x-ray findings.

4. "Movable Kidney." E. T. ABRAMS, Dollar Bay.

5. "Vaginal Celiotomy in Ectopic Pregnancy."

H. E. RANDALL, Flint.

6. "Stenosis of the Cervix."

JAMES D. MATTHEWS, Detroit.

Morphology of cervix and its relation to adjacent structures. A causative factor in dysmenorrhea. A new operation for the more obstinate forms of stenosis.

Second Session, Friday Morning, September 5th

9:00 A. M.

7. "Cesarean Section."

A. M. CAMPBELL, Grand Rapids.

To be illustrated with lantern slides. Report of case and statistics on operations performed in Michigan.

8. "Report of Case of Placenta Praevia."

W. H. MORLEY, Detroit.

9. "The Treatment of Nausea and Vomiting of Pregnancy." FRANK W. LYNCH, Chicago.

10. "Emptying the Uterus as One of the Methods of Treating Antepartum Eclampsia."

REUBEN PETERSON, Ann Arbor.

Synopsis.—Whatever the true causes, eclampsia is due to an intoxication induced by the pregnant state, the termination of which is of advantage to the patient. The best results come from a rapid emptying of the uterus, as soon after the first convulsion as possible, by the methods best adapted to the case and most beneficial to mother and child. Failure to obtain good results have been due to: (1) the wasting of valuable time in other forms of treatment; (2) improper selection of method, so that the patient was subjected to prolonged anesthesia and great trauma; (3) sepsis, resulting from improper technic, in patients whose powers of resistance have been greatly lowered by the eclamptic poison. To obtain better results in antepartum eclampsia, it is necessary to: (1) deliver the woman as soon as possible after the first convulsion; (2) employ a method which not only will empty the uterus quickly, but will also provide for the maximum safety of both mother and child.

11. "Toxemia of Early Pregnancy, with Case Reports."

RICHARD R. SMITH, Grand Rapids.

Third Session, Friday Afternoon, September 5th

1:45 P. M.

Election of officers.

12. "The Heart in Pregnancy."

HUGO A. FREUND, Detroit.

13. "Pulmonary Tuberculosis and Pregnancy."
BENJAMIN R. SCHENCK, Detroit.
Synopsis.—An estimate of the frequency. Influence of pregnancy on pulmonary lesions. Influence of tuberculosis on the pregnancy. Influence on child. Does the old teaching, "fille, pas de mariage; femme, pas de grossesse; mere, pas d'allaitement," hold truth in the light of our present knowledge?
14. "Technic of Transposition Operation for Cystocele and Prolapse."
THOMAS F. WATKINS, Chicago.
Discussion of some of the more important features of the technic. Consideration of the principles involved in the operation. Results.
15. "Chronic Appendicitis in Which the Signs and Symptoms Are Not Directly Referable to the Appendix."
WM. F. METCALF, Detroit.
16. "Gall-Stones First Discovered at the Time of Pelvic Operation."
AGNUS MCLEAN, Detroit.

SECTION ON GENERAL SURGERY

Chairman—Robert J. Hutchinson, Grand Rapids.
Secretary—R. C. Stone, Battle Creek.
(The secretary will collect all papers as soon as they are read.)

First Session, Thursday Afternoon, September 4th 1:45 P. M.

1. Chairman's Address.
R. J. HUTCHINSON, Grand Rapids.
2. "Modern Treatment of Fractures."
M. L. HARRIS, Chicago, Ill.
Synopsis.—Diagnosis: Manner in which force is applied, as characteristic fractures result from the application of force applied in a definite manner. Patients should be made familiar with conditions of fractures and possible outcome. Treatment.
3. "Bone Grafting for Pott's Disease and Ununited Fractures."
MAX BALLIN, Detroit.
4. "Bone Cysts and Sarcomas: Diagnosis and Treatment."
DEAN LEWIS, Chicago, Ill.
5. "Direct Blood Transfusion."
J. WALTER VAUGHAN, Detroit.
 1. Indication for direct transfusion.
 2. The technic of direct blood transfusion.
 3. Simplified methods of performing transfusion.
 Discussion—W. E. McNamara, Lansing; J. J. Reyecraft, Petoskey.

Second Session, Friday Morning, September 5th 9:00 A. M.

6. "Aspiration of Urinary Bladder."
FRED H. COLE, Detroit.
7. "Supra-Pubic Prostatectomy."
ANGUS MCLEAN, Detroit.
Diagnosis—Operative technic.
After treatment. Dangers of operation.
8. "Chronic Cystic Mastitis."
EDWARD S. JUDD, Rochester, Minn.

9. "The Abdominal Skin Reflexes in Acute Inflammatory Skin Conditions in the Abdomen and their Significance."
RICHARD R. SMITH, Grand Rapids.

Synopsis.—"The author has made a study of the abdominal reflexes in 100 cases of acute abdominal conditions and draws conclusions therefrom as to their diagnostic value. In conjunction with other symptoms, the condition of the reflexes has a certain amount of corroborative value, but may not be too much relied on."

10. "Tubercular Peritonitis."
D. E. ROBINSON, Jackson.
Report of case. Three celiotomies.
Tuberculin. Recovery.

Third Session, Friday Afternoon, September 5th 1:45 P. M.

- Election of officers.
1. "Internal Medicine the Basis of Good Surgery."
H. B. GARNER, Detroit.
 1. Complete diagnosis necessary in all surgical cases.
 2. Brief review of advancement in medicine and surgery during past 125 years.
 3. Knowledge of internal medicine and years of bedside experience necessary for making complete diagnosis.
 2. "Shall the Total Death Rate in Cancer be Ascribed to Malignancy?"

WILLIAM FULLER, Chicago, Ill.

Synopsis.—The past and present death rate in malignant disease is not due entirely to "malignancy," but in a large per cent. of the cases to careless and untrained medical men. This must in part apply to the profession as a whole, but more particularly to that part of the profession whose work brings it in first contact with the cancer subject. It is that professional brother, be he specialist or general practitioner, who, when he first sees the patient, overlooks the usual cancer sites, forgets the cancer-bearing age, is unfamiliar with the precancer lesion, and fails finally to correctly diagnose beginning cancer, that should bear the brunt of this criticism; it is this medical man, regardless of his position in the profession, who should seriously study the question of cancer as it stands to-day, when he will agree to the proposition that it is not always "malignancy" that kills in this disease, but very frequently a procrastinating medical attendant.

The incidence of cancer is thought to be increasing, but whether this is true or not does not concern us as clinicians; we do know, however, that it is not decreasing, and that our present results in the treatment of this disease are deplorably bad. The present methods of obtaining reports on the end results of operative work are deficient and of little value, if not often productive of great harm, and should speedily be amended.

On the assumption that cancer, generally speaking, is first a local change, as a rule accessible, and therefore amenable to surgical treatment, should not often leave an excuse for the physician who overlooks so important a condition; and when he is finally held responsible to the law in thus consigning to a cruel fate the victims of malignant disease, a very notable reduction in the number of cancer deaths will be made.

3. "Injection of Boiling Water in the Treatment of Hyperthyroidism."

MILES F. PORTER, Ft. Wayne, Ind.

Theories regarding the cause of the symptom complex known as exophthalmic goiter, and review of some of the more important methods of treatment, giving their advantages and disadvantages and the reasons therefor. Injections of boiling water; technic; occasions for failure; character of cases in which it is advised.

4. "Present Status of the X-Ray in the Diagnosis of Diseases of the Stomach."

P. M. HICKEY, CHARLES D. AARON, Detroit.

Normal form, size and position of the stomach. Rhythmic undulations and gastric cycle. Time of gastric evacuation. Changes in position of the stomach. Position of stomach in chronic appendicitis. Ulcer. Hour-glass stomach. Carcinoma. Cardiospasm and pylorospasm. Dilation. Lantern slide demonstration.

5. "X-Ray Aid in the Recognition of Gastric and Duodenal Ulcer." J. T. CASE, Battle Creek.

COUNTY SECRETARIES' ASSOCIATIONS

Fifth Annual Meeting

Wednesday Afternoon, September 3d

3:00 P. M.

Masonic Temple

President—Charles E. Boys, Kalamazoo.

Secretary—C. T. Southworth, Monroe.

ORDER OF BUSINESS

1. Call to order by the President.
2. Roll Call.
3. President's Address. Charles E. Boys, Kalamazoo.
4. Address by President of the State Society, Walter H. Sawyer, Hillsdale.
5. "Paper, 'The Social Relation of a Medical Society to Its Membership.'" Roland Clark, Wayne County.
6. Address by the Secretary of the American Medical Association. Alex. R. Craig, Chicago.
7. Paper, "Shall the Programs of the County Meetings Be Made Up of Home Talent or by Invited Guests Outside the County?" E. M. Highfield, Gratiot County.
8. Dinner as Guests of the State Council.

NOTE.—No discussers have been selected to open the discussion of the papers. It is expected that every secretary will participate in the discussion. During the

dinner an opportunity will be presented to discuss the various problems with which the county secretary has to contend and to ascertain how the secretary of the other county accomplishes his work. No secretary can afford to miss this meeting. No county should neglect to insist that its secretary attend this meeting.

ENTERTAINMENT

Wednesday Evening, September 3d.—Informal smokers at the hotels. It will be necessary for the members of the Council, the House of Delegates and the County Secretaries to arrive in Flint during the afternoon of the 3d in order that they may attend the first sessions of their respective meetings. These smokers have been provided for them and for the early arriving members.

Thursday Afternoon, 4:30 o'clock.—Visit to the Buick automobile plant.

Thursday Evening, 8 o'clock.—President's reception. On the lawn of the Oak Grove Hospital. To be followed by a dance.

FOR THE VISITING LADIES

Thursday Afternoon.—The ladies will be entertained at the Country Club.

Thursday Evening.—President's reception and dance.

Friday Afternoon.—Automobile rides around Flint.

REGISTRATION

The members are requested to register as soon as possible after their arrival. The Registration Bureau will be located in the main entrance of the Masonic Temple.

PRIVATE ROOMS AND BOARDING PLACES

The Entertainment Committee assure us that they will be able to comfortably care for every member that attends. First-class rooms in private homes may be secured by addressing: Dr. F. B. Miner, 400 South Saginaw street, Flint, Mich.

HOTELS OF FLINT

Hotel Dresden, official headquarters, 300, American. Rate, \$2.50 up.

Hotel Bryant, 100, American. Rate, \$2.25 up.

Hotel Reed, 64, American. Rate, \$1.25 up.

Hotel Crystal, 62, American. Rate, \$1.25 up.

Hotel Dayton, 46, American. Rate, \$1.25 up.

Chairman Hotel Committee, Dr. W. G. Bird, Flint.

Chairman Private Rooms Committee, Dr. F. B. Miner, 400 South Saginaw street, Flint.

AUTOMOBILE GARAGES

Storage Rates.

Flint Garage, 913-915 South Saginaw street. Storage, 50 cents per night.

Auto Sales and Supply Company, corner Court and Saginaw streets, 75 cents per night.

Park Garage, corner Detroit and E. Second avenue, 50 cents per night.

Automobile Exchange, 514 North Saginaw street, 50 cents per night.

Gasoline, oil, wash and polish at standard rates.

The JOURNAL

of the
Michigan State Medical Society

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

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All communications relative to exchanges, books for review, manuscripts, news, advertising and subscriptions are to be addressed to Frederick C. Warnshuis, M.D., 91 Monroe Ave., Grand Rapids, Mich.

The Society does not hold itself responsible for opinions expressed in original papers, discussions, communications or advertisements.

Subscription Price—\$2.00 per year, in advance.

SEPTEMBER

Editorials

CURETTAGE

Consistent with the teachings of modern gynecology, the curet should not be employed indiscriminately, but mainly as follows: (1) To obtain curettings for microscopical examination in cases of suspected malignancy; (2) for the diagnosis and treatment of certain pathological conditions of the uterine mucosa, which give rise to menorrhagia, metrorrhagia or both (we refer chiefly to gland hypertrophy, hyperplasia of the endometrium—Cullen), *dense uterine stroma* and *large venous sinuses*; (3) for the removal of non-infected remnants of an incomplete abortion or miscarriage; (4) for the treatment of dysmenorrhea in some instances.

It is now generally conceded that leucorrhea is rarely the result of endometritis, but mainly arises from existing cervicitis and occasionally from adnexal disease. To curet the uterus for the cure of leucorrhea when its etiological factor exists in the adnexa, would be as consistent as curetting the nasal mucous membrane in an effort to relieve symptoms that arise from antrum in-

volvement; moreover, curettage in cases of pelvic inflammatory disease opens new channels for infection, and may cause a "flaring up" of latent processes with disastrous results. The cervicitis if not associated with extensive laceration and eversion of the cervical mucosa may, in many instances, be relieved by the local application of a strong solution of silver nitrate or by burning with the Pacquelin cautery. If lacerations with eversion exist, trachelorrhaphy or amputation of the cervix are the only means by which the leucorrhea may be cured. If the leucorrhea be a result of disease of the adnexa, attention must be directed toward the treatment of the pathological conditions that are causing the symptom.

True endometritis is comparatively rare and the small number of cases in which it does exist, justifies one in expressing his objection to curettage as a routine procedure in plastic repair of the cervix, vagina and perineum. The term *endometritis* has been greatly abused or misused. (In the annual report of a Michigan hospital the diagnosis is given of endometritis in 68 out of 326 gynecological cases—20 per cent. [?].) It should not be applied to those pathological conditions of the uterine mucosa which do not show microscopically the true picture of inflammation. In *gland hypertrophy*, unassociated with pregnancy, *hyperplasia of the endometrium*, *dense uterine stroma* and *large venous sinuses*, the stroma shows practically no infiltration with polymorphonuclear leukocytes or small round cells. The term endometritis applied to these conditions is a misnomer.

In view of these holdings of our leading gynecologists, the practitioner will no longer be justified in advising and causing a woman to undergo a curettage for the cure of leucorrhea, "catarrh of the womb," and for cervicitis. We realize that some hold that a curettage will correct a retroflexion or a displacement. While we admit that a woman suffering from malposition of the uterus and from leucorrhea may be temporarily benefited after a curettage, still we hold that the beneficial results are due to the rest in bed, rather than to the curettage. It is but a short time before she is again seeking relief from her condition. *Unless the etiological factor is sought and treatment directed toward its removal, we cannot hope to bring relief to the sufferer.*

Knowing then, as one should, that indications for curettage as formerly considered, for the cure of leucorrhea, etc., are fallacious, the time is then at hand when we should be consistent with our present-day knowledge and no longer perform a surgical operation which cannot be credited as being of marked curative value. We must add,

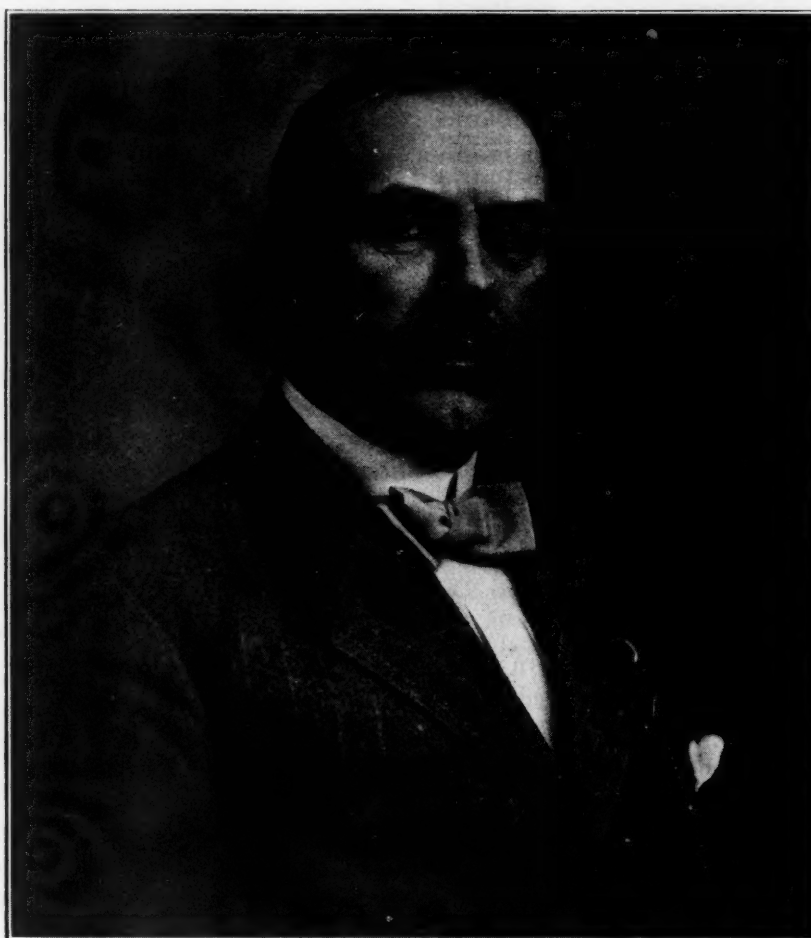
however, that in every case of abnormal uterine bleeding the etiological factor must be determined and in many instances the curet is the only hope. Every curetting should be examined microscopically. Reliance on naked eye appearances may be followed with disastrous results.

DR. WALTER H. SAWYER, PRESIDENT
MICHIGAN STATE MEDICAL
SOCIETY

It is the privilege of few men to enjoy the confidence of their professional associates to the extent that does the President of the State Med-

tion, from New Mexico when lumber is moving actively, from Lansing when the legislature is deliberating on medical bills, from Ann Arbor when the Regents are in session, from Flint when Oak Grove Hospital's directors are meeting, and lastly, from Hillsdale, his place of residence, where he enjoys the complete confidence of a large clientele to which he is devoted and whose medical interests he will not renounce in spite of the large demands which civic affairs and business affiliations make on his time and energies."

Dr. Sawyer is a man of rare business sagacity, far-seeing, prudent, appreciative of difficulties, tolerant of mistakes, encouraging in adversity



WALTER H. SAWYER, M.D.

ical Society, Dr. W. H. Sawyer of Hillsdale. In one of the speeches placing him in nomination, a historic remark made in a memorable convention of long ago was paraphrased something as follows:

"If you ask whence comes our candidate, we answer, not from Appomattox, although he would surely have been at Appomattox or in some situation under fire, serving his country, had he been of age at the time of the late Civil War, but from Cadillac when the blast furnaces are in opera-

and never willing to withhold approval of success and accomplishment. Association with him is a constant source of stimulation and help to those engaged in the activities which have also enlisted his thought and interest. He has a wide fund of information, is of literary and scholarly tastes, loves men and to those who have heard his stirring, hearty, contagious laugh, the assurance that he is sociably inclined is wholly unnecessary.

There is no man in the profession of Michigan who has worked more loyally for better stand-

ards, who has served more conscientiously on the committees of its representative bodies or given more time to working out problems for its betterment than our president. Yea, in the opinion of the writer of this appreciation there is no man to whom the profession is so deeply indebted as to Dr. Sawyer for the gradual and judicious evolution of bills concerning medical practice and their enactment into laws. From the moment his name was proposed for the presidency of the Michigan State Medical Society there was never any question of election, which was unanimous, there being no opposing candidate.

Dr. Sawyer is 52 years of age and has been a member of the Michigan State Medical Society since 1892. He was born in Lime Township, Huron County, Ohio, being the son of George and Julia A. Sawyer. His parents were of English descent, emigrating in the early thirties and settling in the western reserve of Ohio. He received his early education in Eaton Rapids and completed a high school course in Grass Lake, whither the family had moved, in 1880. After three years in the Homeopathic Department of the University of Michigan, he was graduated in 1884. After graduation he filled the position of house surgeon to the hospital for one year. In the year 1885, he located in Hillsdale in the practice of scientific medicine, unhampered by any consideration of sect. Such practice he consistently followed. He was married in 1888 to Harriet B. Mitchell, daughter of the late C. T. Mitchell, Esquire, of Hillsdale. He has one son, Thomas Mitchell Sawyer.

He was appointed to the State Board of Registration in Medicine in 1900, and served until his election four years ago to the Regency of the Michigan University. To the latter position he was reelected in the present year. He was chairman of the committee on legislation and public policy of the Michigan State Medical Society from 1904 to 1911. He is a member of the Board of Directors of Oak Grove Hospital and vice-president of that corporation. He is a member of the Episcopal Church and of Eureka Commandery, No. 3, Knights Templar; has been a trustee of Hillsdale College since 1894. In political affiliation he is a Republican, and has as a patriotic duty taken part in local, state and national campaigns. He has approved of the presence of the doctor in politics, is a believer in organization and of the increased effectiveness of work "where two or three are gathered together." His life furnishes a fine example of success attained through deserving. He is, in the lan-

guage of Wordsworth, one of those "by their good deeds exalted." The Society chose its present president wisely, were it for no other than the selfish reason that "trust reposed in noble natures obliges them the more." C. B. B.

OUR INVITED GUESTS

The following invited guests, men of national reputation, will address the several scientific sessions at the annual meeting, September 4th and 5th.

HONORABLE WOODBRIDGE N. FERRIS, Governor of Michigan. Governor Ferris' interest in medical legislation and public health matters was manifested during our last legislature. His address promises to be of interest and undoubtedly will contain a timely message to the profession.

EDWARD JUDD, Surgeon, Mayo Clinic, Rochester, Minnesota. His work and writings have gained for him a national reputation. His paper, "Chronic Cystic Mastitis," will be deserving of our closest attention.

ROBERT H. BABCOCK, Chicago, Illinois. Dr. Babcock needs no introduction to the profession of Michigan. His reputation as an authority has been long established. His address on "Presentation and Discussion of Specimens Illustrating Endocarditis Caused by *Streptococcus Viridans* and the *Streptococcus Rheumaticus* and Points of Difference in their Clinical Manifestations," before the Section on General Medicine will merit a large audience.

MILES F. PORTER, SR., Professor of Surgery in the Indiana University School of Medicine, Fort Wayne, Indiana. Dr. Porter has appeared before several of our county societies. Known nationally as a most capable surgeon, an original investigator, a forceful speaker, we are fortunate in securing his presence at this meeting.

THOMAS J. WATKINS, Clinical Professor of Gynecology, Northwestern University Medical School, Chicago, Illinois. Dr. Watkins is known by reputation to our gynecologists. His address, "The Transposition Operation in the Treatment of Cystocele," will be of interest and value to the general practitioner as well as to him who devotes himself exclusively to gynecology and abdominal surgery.

DEAN DE WITT LEWIS, Assistant Professor of Surgery, Rush Medical College, Chicago. Dr. Lewis' special work in nerve surgery and the transplantation of muscles in cases of paralysis

is well known and lends additional interest to the announcement that he will appear on the program of the surgical section.

FRANK W. LYNCH, Assistant Professor of Obstetrics and Gynecology, Rush Medical College, Chicago. Dr. Lynch's well known work in gynecology and obstetrics needs no assurance on our part to the members of the State Society that his paper on "The Treatment of Nausea and Vomiting in Pregnancy" will be of exceptional interest and practical value to the general practitioner as well as to the specialist in the diseases of women.

MALCOLM L. HARRIS, Professor of Surgery, Illinois University Medical School, Chicago. Were Dr. Harris one of their own number, the profession of Michigan could have no better knowledge of his work in general surgery than they already have. It is therefore with pleasant anticipations that we await his paper on "Modern Treatment of Fractures."

ORVILLE W. MCMICHAEL, Chicago. Dr. McMichael's paper on "The Diagnosis and Treatment of Tuberculosis" is one that will appeal to the majority of the members in attendance at the annual meeting.

WILLIAM FULLER, Professor of Operative Surgery and Adj. Professor of Clinical Surgery, University of Illinois, Chicago. Owing to Dr. Fuller's opportunities for study and research along this line his paper entitled, "Shall the Total Death Rate in Cancer Be Ascribed to Malignancy?" will command unusual interest.

The above brief sketches of our guests precludes the necessity for further comment. The officers of the sections are to be congratulated on their efforts in thus securing the presence of such an array of invited guests. We trust that every member will hesitate a long time before definitely determining that he will not attend this meeting and thus forego the privilege of hearing and meeting these men of national repute.

THE FORTY-EIGHTH ANNUAL MEETING

A careful reading of the program, the noting of the names and personnel of the invited guests—nine of them—who are to be present and who will participate in the programs of the various sections, warrant the prediction that this is going to be a profitable and instructive meeting.

Further, there isn't a member who will attend this meeting, but will go home a better physician, better able to meet and solve the problems of his practice, and who will be inspired to do better

and more scientific work consistent with the latest and accepted theories and teachings. He will be a better doctor than the one who stayed at home. There isn't a member who can afford to forego this Flint meeting. If he does, he will sustain a distinct loss; he will have let a valuable opportunity pass by unutilized—neglected. The profession of Flint and Genesee County cordially invite you. They want you to come early and stay to the very end.

The House of Delegates will meet at 8 o'clock Thursday morning, September 4. The delegates are urged to arrive in Flint so as to be in attendance on this first session.

The General Session on the first day will be called to order at 10:30 a. m. The addresses of President Sawyer and Governor Woodbridge N. Ferris and the discussions that follow promise to be of exceptional interest and germane to the personal interest of each physician. The assembly hall should be crowded to its utmost capacity during this session.

The published programs of the sectional work are in themselves indicative of profitable instruction and scientific worth. The section officers are commended and deserving of the unanimous thanks of the Society for having put so much effort and time in their work in arranging for the presentation of so many valuable papers. There is every opportunity for you to show your appreciation of their efforts by engaging in the discussions of the various papers read.

The Flint physicians have not neglected the entertainment features and the reception and dance on Thursday evening promises to be a memorable and enjoyable function.

Once again, and for the last time, we desire to impress on each member—you will sustain a distinct and inestimable loss if you permit this Forty-Eighth Annual Meeting to pass without your being in attendance on the entire session.

Editorial Comments

REGISTER as soon as possible after your arrival in Flint. Masonic Temple, main entrance.

TO PARTICIPATE in all the sessions you should arrive in Flint on the evening of September 3.

"FOREVER absolve yourself from petty tricks too small to be criminal, but big enough to be unmanly."

THE Flint meeting will witness nine invited guests of national reputation appearing on the scientific program.

You owe it to your clientele, to yourself and to your county and the State Society to attend the Flint meeting.

You cannot hope to be the recipient of the full benefits of organized medicine unless you attend the Flint meeting.

THE annual meeting for 1913 is calculated to provide every one in attendance with two days full of profitable opportunities.

You are reminded to announce your name and residence on rising to participate in the deliberations and discussions of every session. The stenographers will thus be enabled to keep their records complete.

THE Clinical Congress of the Surgeons of North America, to be held in Chicago during the fore part of November, promises to be of inestimable interest, and provisions are being made for a large attendance.

YOUR patients will place a higher value on your services when they know that you have been in attendance on the Flint meeting. They will of themselves know that when you return home you will be a better doctor.

AGAIN we call the members' attention to the advertisements that are inserted in this issue by the business men of Flint. They were secured by Dr. Clark of Flint, and they should receive the patronage of the doctors of Flint and vicinity as well as of the visiting members.

DO YOU desire to obtain greater benefits from your county society? Then it behooves you to contribute a little more time and effort in its behalf each week. You will receive in return just what you give to it and—a good deal more. Just try, and thereby prove our prediction.

UNDER the head of "Correspondence" the reader will find a letter from the secretary of our State Board of Registration, together with certain replies received by him from the attorney-general. It contains information regarding the work of the board and the enforcement of the recent Medical Practice Act. This correspondence should prove of interest to every member, and we feel indebted to Dr. Harrison for permitting us to impart this information.

IN so far as we are able to secure them, each paper on the program is followed by a brief synopsis of its contents. This, we trust, will call forth more general and to the point discussions. Members are also enabled to look up their personal records and data, and in giving their experiences and opinions based on definite facts, the discussions are bound to be more valuable and instructive than a rambling, disconnected dissertation consisting of vague generalities.

A DORMANT adenomatous enlargement of the thyroid—one that has been dormant for a period of years—should not have directed toward it for the purpose of reduction of its size a course of medicinal treatment. While several weeks of such injudicious treatment may result in the reduction of its size, the practitioner will find that the patient's condition at the end of that time will necessitate his attention and treatment in the future to be directed to a myo- or endocarditis.

ARRANGEMENTS have been perfected whereby stenographers will take down the discussions following the addresses of President Sawyer and Governor Ferris. We also feel that the discussions of the papers of the invited guests are going to be of unusual interest and worthy of permanent record, and to that end we have arranged so that a stenographer will be in attendance at the sessions of the various sections. The discussions will be published in THE JOURNAL in connection with these addresses and papers.

THE election of Victor C. Vaughan, Sr., as President-Elect of the American Medical Association is being met with universal approval by the entire organized profession of the country, as evidenced by the favorable comments that are being made by the entire body of editors of medical publications who are expressing the sentiments of their respective localities. Michigan may be pardonably proud of being able to present, from within its borders, a man for this office who is so well known and respected by the organized profession of this country.

YOU are not lending the officers of your county society the cooperation that they merit if you are not actively participating in the work of your organization. In addition, your influence and solicitations are invoked in securing the affiliation of every reputable physician in your county. Interview the non-member, tell him what he is missing, point out to him why he should affiliate

with your society, induce him to join. Your society and its officers expect this assistance from you. You are in duty pledged to thus support them.

WHEN called to see a patient suffering with abdominal pain, the physician should exhaust every effort and means to determine its etiologic factors. Do not pass it by lightly or hurriedly and hastily prescribe an opiate. Thus neglecting it, your next or third visit may unpleasantly reveal that there is existing an appendicitis, gastric ulcer perforating, obstruction, strangulated hernia, gall-bladder or kidney involvement that has advanced to such a degree as to jeopardize the life of the afflicted, whereas early attention, with early institution of the proper form of treatment, would have obviated such a condition. We are lead to utter this reminder by reason of the fact that in the past few days we have seen a gangrenous appendix, a strangulated hernia, an intestinal obstruction go undetected for a period of from three to five days—two of whom were *in extremis* when the true diagnosis was made. Abdominal pain deserves careful investigation.

A CAREFUL record of your cases and their progress and termination will, in five or ten years, become a valuable asset to you. The keeping of case records and case histories are as essential to modern requirements and efficiency as are the reading of your medical journals, laboratory work, post-graduate work and the keeping abreast of the progress of our profession.

Further, such records will be valuable for reference when preparing a paper or taking part in medical discussions. Memory will fail you when endeavoring to recall the result in a single or collective number of cases. A classification and compilation of the results in a given number of cases will permit you to express an authoritative opinion that will be of added weight. The labor entailed is not burdensome. Systematization will enable you to readily accomplish it. This suggestion is urged on you with the hope that you will be influenced to comply with the suggestion.

THE representative and the detail man from the various manufacturers call on you and occupy your time. Why not tell them that they are not treating you fair. Tell them that you believe in reciprocity. They have something to sell and they are asking you to use their preparations and products, and in addition they are utilizing your time in doing so. In return for this inform them that you believe that they should patronize you.

This JOURNAL is *your* journal, and you have advertising space to sell in this journal which they should buy. Patronizing *your* journal and buying advertising space in it will even up the business relationship. The manufacturer will benefit by receiving an increased volume of business. You will benefit by having your journal receive an increase of advertising receipts, which will enable your Publication Committee to send you a larger, better and valuable publication. If every member will engage every traveling man that calls on him in such a discussion it will result in having THE JOURNAL receive a larger number of advertising contracts. May we not ask this from you and at the same time request that you inform the detail man that you are patronizing those who patronize your publication. Having done this, then be sure that you are placing your orders with the firms that are advertising with you. A little cooperation is all that is required. Your assistance is needed.

State News Notes

Dr. Guy L. Connor of Detroit spent the month of July and part of the month of August at Atlantic City.

Dr. Z. M. Moore, formerly of Sparta, has moved to Grand Rapids and associated himself with Dr. Northrup.

Dr. E. A. Chapoton, for many years a member of the Detroit Board of Fire Commissioners, has resigned his office.

The Battle Creek Sanitarium is experiencing a very prosperous year. On August 7 1,600 guests were registered.

Dr. Henry Sethney of Menominee has received the appointment as first lieutenant in the Michigan National Guards.

A supply of the August JOURNAL was sent to the doctors who were on duty with the Michigan troops in the Upper Peninsula.

A baby contest will be held in connection with the West Michigan State Fair to be held in Grand Rapids during the week of September 1.

The Northern Tri-State Medical Association will hold its next meeting in Kalamazoo during January. Dr. G. W. McCaskey of Fort Wayne is the newly elected president of this organization.

Ionia's new hospital, the first of the kind in that city, was opened for the reception of patients on July 17. It is a ten-bed institution.

Dr. Reuben Peterson of Ann Arbor delivered an address before the Mothers' League of Ann Arbor on "The Rights of the Unborn Child."

Dr. A. I. Noble, medical superintendent of the Kalamazoo State Hospital, in his July report stated that that institution had 2,031 patients enrolled.

Dr. J. T. Case and Dr. C. E. Stewart of Battle Creek are in Europe attending the International Congress of Medicine. Both of these doctors appear on the program of this meeting.

Dr. D. Emmett Welsh of Grand Rapids was called to Philadelphia by reason of the serious illness of his sister. The doctor remained with her for ten days during the first part of August.

Newspaper information imparts the announcement that the State Board of Health will select Prof. E. D. Rich of the University of Michigan as the new sanitary engineer of that board. The law providing for the appointment of this officer went into effect on August 14.

Mr. A. A. Hale, who for the past ten years has been engaged in the work of the X-Ray Department of the University of Michigan, the last two years having served as its director, on August 1 assumed charge of the X-Ray Laboratory of Dr. F. C. Warnshuis of Grand Rapids.

Harper Hospital, Detroit, opened its new service building on August 5. A dinner to its medical staff was tendered by the trustees. The second floor of the Hudson memorial building was opened on August 12. These new quarters give the hospital accommodations for 180 additional patients.

Work has been started in Detroit for the erection of an eighteen-story building at a cost of \$600,000. Fifteen stories of this structure will be rented as physicians' offices and will be modern in every detail. The building is being erected on the northeast corner of Adams avenue and Park street. It is to be known as the Kresge Medical Building.

"Dr. Ralph C. Smith is the only physician in Alpena who is not a member of the Alpena Medical Society and he has been made physician for the Alpena lodge of Moose. All the other physicians of that city have signed an agreement against contract work." We congratulate the Alpena profession on their stand and regret that one member of the profession should deem it wise to thus defeat the commendable efforts of his fellow practitioners in endeavoring to eradicate contract work. We sincerely hope that Dr. Smith will soon perceive the error of his action.

We are informed that thus far only two or three applications for registration from chiropractors have been received from Grand Rapids. From this it is inferred that they have formed a combination to fight the recent medical act. This, in view of the Attorney General's opinion, would prevent their registration in the future, from the fact that they have only until October 1 in which to make application. From another source we learn that a large number of the cult are preparing to leave the state. Out of fourteen chiropractors in one city only two are able to qualify for registration, and the others are preparing to leave for

other states. Similar conditions prevail in almost every locality and a general exodus is expected before October 1. We may well be proud of a law that is so effective in ridding Michigan of these undesirable practitioners.

Deaths

Singer, Frank M. Detroit College of Medicine, 1906, Member Michigan State Medical Society, Wayne County Medical Society. Died July 27, 1913, at St. Mary's Hospital, Detroit, as the result of injuries sustained in an automobile accident.

Van Der Veen, Christian. University of Michigan, 1898. Member of Kent County Medical Society, Michigan State Medical Society. Died Aug. 10, 1913, at the Moshier Sanitarium, following acute erysipelas. Aged 40 years.

Society Proceedings

THE NINETEENTH ANNUAL MEETING OF THE UPPER PENINSULA MEDICAL SOCIETY

Between forty-five and fifty members of the Upper Peninsula Medical Society gathered for the Nineteenth Annual Meeting of this organization at Ishpeming on August 6 and 7, and participated in the deliberations of one of the most successful meetings of the society.

Unless one attended the meeting it would be difficult for him to imagine the interest that was manifested by each member in the papers that were presented and the "rattling good" discussion that followed each speaker's paper or talk. It has been rather infrequently that we have had the opportunity of attending a medical meeting in which there prevailed such an earnest interest and in which the papers and discussions were so timely, instructive, practical and consistent with the modern advancements. There was not a single member who attended this meeting who did not return home enlightened and inspired to do better work. It was a program indicative of the men of the Upper Peninsula. The sessions were not tiresome and the entire field of medicine and surgery were represented on the program.

On Wednesday evening of the first day the members sat down to a banquet tendered to the members by the Marquette-Alger County Society. After participating of a sumptuous and appetite-inspiring menu the following program of toasts was carried out:

After-Dinner Talks

Toastmaster—Dr. George G. Barnett.

"Automobilitis, a New Form of Insanity." Dr. C. J. Ennis, Sault Ste. Marie.

"Untold Tales of a Delegate to the National Meeting." Dr. E. T. Abrams, Dollar Bay.

"Our Hosts." Rev. C. G. Ziegler, Ishpeming.

"Reminiscences of the Practice of Medicine in the Early Days." Dr. Benj. T. Phillips, Menominee.

"Our Appetites." Hon. W. T. Potter, Ishpeming.

"Morgan Heights from a Business Point of View." A. J. Yungbluth, Ishpeming.

"Modern Prison Methods." James Russel, Marquette.

"Our Wives and Our Gold Bonds." Dr. C. F. Larson, Crystal Falls.

"What the State Society Intends to Do for Its Members." Dr. F. C. Warnshuis, Grand Rapids, Secretary State Medical Society.

The responses were able and throughout all of them there flowed a happy vein of humor and the "oratorical flights" were the means of concentrating the interest so that it was with considerable regret that the members finally, at 1 o'clock, disbanded after the singing of "Auld Lang Syne."

The scientific sessions ended at noon on Thursday and in the afternoon the members were entertained at the new Morgan Heights Tuberculosis Sanatorium. Here a couple of hours were profitably spent in inspecting the beautiful grounds and buildings, as well as the methods employed in the care and treatment of the patients. After light refreshments served by the sanatorium board of managers automobiles were furnished to convey the members to Marquette, where they made a tour of the State Prison. All in all it was a pleasant afternoon, enjoyed to the uttermost by every participant.

New Officers

During the business session the following officers were elected for the coming year:

President—H. J. Hornbogen, Marquette.
First Vice-President—George G. Barnett, Ishpeming.
Second Vice-President—C. T. Moll, Kenton.
Secretary—Alfred La Bine, Houghton.
Next place of meeting, Houghton.

The following members signed the registration book and were in attendance:

H. J. Hornbogen.....	Marquette
E. H. Flynn.....	Marquette
A. L. Laing.....	Rapid River
W. B. Boyce.....	Escanaba
G. H. Boyce.....	Iron Mountain
Wm. Elliott.....	Escanaba
J. Mitchell.....	Gladstone
A. H. Miller.....	Gladstone
A. S. Kitchen.....	Escanaba
L. R. Kratze.....	Escanaba
Robt. A. Walker.....	Menominee
Isaiah Sicotte.....	Michigamme
J. W. Kirton.....	Ojibway
G. M. Beltheumer.....	Negaunee
F. Townsend.....	Sault Ste. Marie
P. S. Wilson.....	Negaunee
T. M. Cunningham.....	Marquette
A. H. Anderson.....	Negaunee
C. J. Larson.....	Negaunee
H. H. Ptolemy.....	Trenary
H. H. Loveland.....	Republic
G. A. Conrad.....	Houghton
A. J. Carlson.....	Escanaba
G. G. Barnett.....	Ishpeming
A. W. Hornbogen.....	Marquette
H. M. Cunningham.....	Marquette
E. Sawbridge.....	Stephenson
M. P. Fenelon.....	Escanaba
A. I. Lawbaugh.....	Calumet
L. P. Treiba.....	Bark River
Arthur Fischer.....	Hancock
F. M. Harkin.....	Marquette
A. A. Solberg.....	Ishpeming
J. S. Nitteraeur.....	Ontonagon
A. F. Snyder.....	Escanaba
C. F. Larson.....	Crystal Falls
V. H. Vander Venter.....	Ishpeming
T. A. Felch.....	Ishpeming

THE JOURNAL, this issue, contains Dr. Edward Sawbridge's presidential address and we shall endeavor to secure all the papers that were read and publish them in the succeeding issues of our JOURNAL.

The Upper Peninsula may well be proud of their society. It merits the support of every doctor of that region and he who remains unaffiliated is causing himself to forfeit opportunities that are of inestimable value.

UNION MEETING OF SANILAC, HURON AND TUSCOLA COUNTY MEDICAL SOCIETIES

On Monday, August 11, 1913, at the Presbyterian Church in Cass City, a union meeting of Sanilac, Huron and Tuscola County Medical Societies was held.

At 1 o'clock the following program was presented:

"The Feeble-Minded Problem in Michigan." Dr. H. A. Haynes, Lapeer.

"Diagnostic Criteria in the Insanities." Dr. A. E. Christian, Pontiac.

"Congenital and Acquired Adhesions of the Abdomen." Dr. E. E. Brush, Huron.

"Tuberculosis as an Indication for Interrupting Pregnancy." Dr. B. Friedlander, Sebawaing.

"Pyorrhea Alveolaria in Relation to General Health." Dr. W. J. Kay, Lapeer.

A supper was served by the Presbyterian ladies at 5 o'clock.

J. W. SCOTT, Sec'y, Sanilac County.

DANIEL CONBY, Sec'y, Huron County.

W. C. GARVIN, Sec'y, Tuscola County.

KALAMAZOO ACADEMY OF MEDICINE

The July 22, 1913, meeting of the Kalamazoo Academy of Medicine was held in the South Haven Club rooms at 10:30 a. m.

Dr. Mark Marshall of Ann Arbor presented a paper on "The Dietetic Treatment of Gastric Ulcer," and Dr. G. D. Carnes of South Haven gave a "Review of Dr. Cabot's Work on Essentials and Non-Essentials of Physical Diagnosis."

Immediately following adjournment the members of the Academy were entertained at luncheon at the Johnson House in South Haven, as the guests of the physicians of South Haven, after which a boat ride on the river was enjoyed.

C. B. FULKERSON, M.D., Secretary.

EATON COUNTY

The Eaton County Medical Society held its regular meeting in Charlotte on Thursday, July 31. The following program was observed:

Business session and clinic at the hospital, 11 a. m.
Afternoon session at the court house.

Paper: "Neosalvarsan." Dr. Berten Davey of Lansing.
C. S. SACKETT, M.D., Secretary.

GRATIOT COUNTY

At the regular meeting of the Gratiot County Medical Society at the Wright House in Alma, Thursday, Aug. 14, 1913, the following program was given:

"Diseases of the Thyroid." Dr. H. F. Kilbourne, Perrington.

"Acute Appendicitis in Children." Dr. C. B. Gardner, Alma.

"Diagnosis and Treatment of Typhoid Fever." Dr. F. R. Blanchard, Lakeview.

"Diabetes." Dr. J. R. Schaffer, Elm Hall.
E. M. HIGHFIELD, Secretary.

INGHAM COUNTY

At Pine Lake on Tuesday afternoon, August 5, was held the annual picnic of the Ingham County Medical Society. Refreshments were provided by the doctors' wives and a very enjoyable luncheon was served at 1 o'clock.

A short business meeting occupied a portion of the time in the afternoon, several important subjects being discussed. H. S. BARTHOLOMEW, M.D., Secretary.

MONROE COUNTY

The annual mid-summer meeting of the Monroe County Medical Society was held at the Monroe Yacht Club on Thursday, July 17. There were fifteen members present. We had as our guest Dr. George M. Todd of Toledo, Ohio. No papers were read, but Dr. Todd gave an informal talk on "Tumors of the Tongue."

A chicken dinner at the Hotel Lotus was followed by a boat ride on the lake.

C. T. SOUTHWORTH, Secretary.

Correspondence

MICHIGAN STATE BOARD OF REGISTRATION IN MEDICINE

DETROIT, MICH., July 19, 1913.

Dr. F. C. Warnshuis, Secretary-Editor, State Medical Society, 91 Monroe Ave., Grand Rapids, Mich.:

My Dear Doctor:—For your information, I enclose you copies of blanks approved by the board at its June meeting, and endorsed by the attorney-general. It seems to me that these blanks will furnish accurate information covering the actual enforcement of the exemption to the drugless healers, and prevent fraud in the registration of those persons who have not reputably graduated from cult colleges.

I have had a good deal of correspondence with the attorney-general, covering the legal points involved in the registration of cult applicants under the exemption in Section 3, subdivision third, and I enclose you some of the more material opinions obtained. In reply to one letter, in which I asked the attorney-general what, in law, constituted an incorporated college, he stated as follows:

"I have no doubt that the college referred to in this proviso must be a reputable one, and that the statute contemplates an actual attendance at such college and a graduation therefrom in accordance with the ostensible requirements as published. Under the authority of the cases, *Metcalf vs. State Board of Registration*, 123 Mich. 661, and *People vs. Reetz*, 127 Mich. 87; 188 U. S. 505; a state board of registration has the undoubted right to pass on the facts as to whether or not the requirements imposed by the statutes have been fulfilled within the contemplation of the law, such power not being, in the strict sense of the term, an exercise of a judicial function."

You will see, therefore, that the board will be obliged to go over each cult application for registration separately, and determine the fact, not only of graduation

and two years' subsequent practice in Michigan, but will have to decide as to the reputability of the school from which the applicant graduated and the course pursued in such school, in addition to the fact as to whether the school was legally incorporated two full years, plus the course advertised, prior to Sept. 1, 1913. From information thus far obtained it would appear that very few of the cult colleges have lived up to their published requirements, either in this or in other states.

We threshed this matter out some years ago, in the cases quoted above, viz., the *Metcalf* and *Reetz* cases, and the board was sustained, not only by the Michigan Supreme Court, but by the United States Supreme Court. Undoubtedly we will have a great many applicants for registration under the exemption clause of section 3, subdivision third, of the 1913 medical act, but through a proper method of administration a very large percentage of such applicants can be refused certificates under the law. In the event of a drugless healer applying for a board examination, he must first comply with the preliminary requirements of a standard equal to that demanded of a legally qualified medical man.

The so-called Michigan State Chiropractic Society held a meeting here in Detroit this week, and dissolved the association. A further association was formed, which I believe is to be designated "The Drugless Healers' Protective Association." This association has in view the possibility of the supreme court declaring the 1913 amendments unconstitutional. As noted by Attorney-General Fellows in his letter to me under date of May 28, they have very little chance of success, and the only possible result, even if the attorney-general is not supported by the supreme court in his general opinion, which I think very improbable, would be to cut out subdivision third of section 3, while the remainder of the act would stand. I had this in mind when writing the amendments, and kept all matter relative to cults out of the other provisions of the act. This would, therefore, result in their amending the act through a supreme court decision, in which the provision for their registration would be cut out, leaving the remainder of the act, including the definition clause, intact. From the standpoint of the medical profession, the elimination of this clause would leave the cult proposition entirely within the penalty clauses of the medical act, with no method for the legal registration of drugless healers.

You will probably remember that in 1900 we put out of business several hundred fake college graduates who had registered under the 1883 act, and this was accomplished largely through administrative methods.

Recently the supreme court decided an appeal case against Drs. K. & K., and in its decision called attention to the fact, that while Drs. K. & K. avoided the use of certain words prohibited in advertisements, "words and phrases just as effective in conveying the meaning were employed." This demonstrates that the Michigan Supreme Court construes the law, not on technicalities, but strictly in accordance with the intent of the legislature. The matter of the rescinding of the licenses of Drs. K. & K. will be taken up at the October meeting of the board, on the filing with it of a certified copy of final conviction. We have at least one other final conviction license to cancel at the above meeting.

I should be very glad, indeed, to furnish you with further detailed information, if necessary, and should also be glad to receive any suggestions you may think proper.

With kind regards,

Very sincerely yours,

B. D. HARISON, Secretary.

STATE OF MICHIGAN,
ATTORNEY GENERAL'S DEPARTMENT,
LANSING, May 28, 1913.

Beverley D. Harison, M.D., Secretary State Board of
Registration in Medicine, 504 Washington Arcade,
Detroit, Mich.:

Dear Sir:—Your communication of the twenty-seventh instant, relative to the constitutionality of certain portions of the law amending the General Medical Act, enacted at the last session of the legislature is before me.

I note that some question has been raised relative to the third subdivision of section 3, as amended, it being contended that the provisions of said subdivision are not within the scope of the act as indicated in its title.

In reply I would say that if the third subdivision of section 3 should be held unconstitutional and void, such holding would not, in my judgment, affect the other provisions of the act. It is the general rule that where the different parts of the law are not so closely related as to be mutually interdependent the unconstitutionality of one provision will not be construed to affect the validity of others not subject to the same objections. I do not, however, wish to be understood as conceding the invalidity of any portion of the act in question. Rather, I am impressed that the title is sufficiently broad in its scope to include any and all provisions incorporated in the body of the act. The title reads as follows: "An act to provide for the examination, regulation, licensing and registering of physicians and surgeons, and for the punishment of offenders against this act and to repeal acts and parts of acts in conflict therewith."

The word "physician" as here used must be taken to mean, in my opinion, one who is legally entitled to engage in the practice of medicine. It is specially provided in the act itself, in section 9, thereof, that "the practice of medicine" shall be taken to mean "the actual diagnosing, curing or relieving in any degree, or professing or attempting to diagnose, treat, cure or relieve any human disease, ailment, defect or complaint, whether of physical or mental origin, by attendance or by advise, or prescribing or furnishing any drug, medicine or appliance, manipulation or method, or by any therapeutic agent whatsoever." This definition is certainly sufficiently broad enough in its terms to include those specified in the third subdivision of section 3 who desire to practice a system not involving the use of drugs, medicine or surgery. In other words, while we do not ordinarily think of the persons provided for in the subdivision as being physicians, yet it is my opinion that the word as used in the title of the act must be deemed to include such, notwithstanding that they are expressly forbidden to use the specific titles permitted to those who are qualified to practice under the first two subdivisions

of section 3. The inhibition with reference to the use of certain medical designations was undoubtedly incorporated into the law for the purpose of preventing confusion or imposition on the public. It cannot, in my judgment, be construed as indicating any intent on the part of the legislature to declare that the persons specified in the subdivision are not to be considered physicians in the broad sense in which that word was evidently used as indicated by the definition of the phrase "practice of medicine" found in section 9.

It further occurs to me that if this subdivision were entirely eliminated from the act and no provision made for those for whom it is intended to provide therein, any person practicing such a system as is contemplated for the relief of human ailments without the use of drugs, medicines or surgery, would be guilty of a violation of the provision of the act. This would, of course, necessitate a finding that they were practicing medicine within the statutory definition, and that any such person was acting or professing to act as a physician. It can, I think, be scarcely argued with any degree of plausibility that a particular class of people may not be provided for under the title of this act, but that individuals of that class may be prosecuted criminally on the ground that they are practicing medicine within the meaning of the law, if the subdivision in question were entirely eliminated.

I find that the question involved here has been passed upon by the courts of last resort of several states. In the case of *Smith vs. People*, 117 Pacific, 612, it was held that one who professed to be a "healer" and to possess divine inspiration must be deemed to be practicing medicine under the provisions of the statutes of Colorado, even though he used no drugs, medicines or surgical appliances. In the recent case of *State vs. Corwin*, 131 N. W. 659, the Supreme Court of the State of Iowa has held that a chiropractic must be deemed to be practicing as a physician under the code of that state, which contains a provision that any one shall be deemed to be practicing medicine, and a physician, if they profess to cure or heal. This case is also interesting as indicating the proper construction to be placed on the word "physician," the view taken being as indicated above. Similarly the same conclusions as were reached in the above cases have been adopted by the Supreme Court of the State of Indiana in the case of *Witty vs. State*, 90 N. E. 627, which holds that one practicing osteopathy must be deemed to be practicing medicine. To the same effect are the cases of *State vs. Adkins* (Iowa), 124 N. W. 627, and *Bandel vs. Department of Health* (N. Y.), 85 N. E. 1067.

In view of these authorities, the broad definition of what is meant by the practice of medicine as laid down in the statute, and the resultant scope that must be given to the word "physician" as used in the title of the act, it is my opinion that no portion of the act in question is open to attack on the ground that it is not embraced within the scope of the act as indicated by the title.

Trusting that I have indicated my position in the matter, I am,

Very respectfully yours,

(Signed) GRANT FELLOWS,
Attorney General.

STATE OF MICHIGAN,
ATTORNEY GENERAL'S DEPARTMENT,
LANSING, June 30, 1913.

Dr. Beverley D. Harison, 504 Washington Arcade,
Detroit, Mich.

Dear Sir:

I am in receipt of your communication of the 26th inst., enclosing certain blanks to be used by your board under the provision of the amendment to the medical act enacted at the session of 1913. Pursuant to your request, I have examined the different blanks submitted. I notice no feature of any of them that is objectionable from a legal standpoint. I have no doubt that it was the intention of the legislature to vest the State Board of Registration in Medicine with a considerable measure of discretion relative to these matters. It seems to me that the various points covered by the blanks submitted are entirely proper. In order that the board may perform its duties as contemplated by the statute, it will, of course, be absolutely necessary that it be supplied with the required information with reference to the qualifications of applicants for registration.

I am returning herewith the different forms enclosed by you.

Respectfully yours,

(Signed) GRANT FELLOWS,
Attorney General.

County Secretaries' Department

THE JOURNAL is the official publication of your organization. It is one of your duties to supply THE JOURNAL with the reports of your meetings and your members expect that you shall fulfil this trust. Please do so.

In order that this department may more fully meet the purpose for which it was established, it is desired that all secretaries lend it their co-operation by sending in their views, experiences and suggestions regarding their work and their successes and failures. May we not be the recipient of something along this line from you for our next issue?

The county secretaries of the state are requested to mail a postal card to every one of their members urging that they attend the annual meeting at Flint on September 4-5. Kindly comply with this request and also urge that your society be represented through a majority of your members.

There are certain members of the various county societies who are still in arrears with their 1913 dues and are consequently upon the suspended list. These members should not be permitted to step down and out of the ranks of organized medicine without the effort being made

to interview them and thus inducing them to become members in good standing.

Will you endeavor to see those of your society who are thus in arrears and point out to them the loss they are sustaining by permitting their names to remain on the suspended list? Will you not report to this office the result of these interviews so that we may be of assistance to you?

The fall of the year is at hand, and those of our county societies that have been taking a summer recess will commence resuming their meetings during the middle and latter part of September. Plans for your winter's program should commence demanding your attention. Unless you plan sufficiently long beforehand, you cannot expect to present to your members a series of papers that will supply their requirements or expectations. It goes without saying that an attractive program is essential to a good meeting.

This question of programs, how to arrange them, nature of papers, invited guests, discussions and publicity, will be a topic that will receive consideration at the secretaries' meetings. We desire that you participate in the discussion, relate methods and experiences and also be enabled to secure new and practical suggestions through the obtaining the experiences and ideas of your brother secretaries.

Every county secretary of the state is urged to be in attendance at the County Secretaries' Association meeting which will be held on Wednesday afternoon, September 3, at 3:00 p. m.

The program of the meeting and the discussions that are to take place will have a vital bearing on the work of each county secretary. So vital and important will be the transactions of this session that no secretary can neglect to attend. Your loyalty to your county and state societies demands your presence.

Dr. Alexander R. Craig, Secretary of the Medical Association, will address the meeting on Organization Work and How to Build Up a County Society.

Dr. Sawyer, President of our State Society, will also deliver a talk that will bear on the relation of the state to the county society.

The remainder of the program will be found elsewhere in this issue. The formal program will be followed by a dinner that will be tendered to the secretaries by the Council. At this dinner there will be a number of informal talks on secretaries' problems and will bear on programs, business methods, social features, guests, and similar phases of the work of a secretary.

In view of all this we trust that no secretary will fail to attend; his presence at this meeting will result in his being a better secretary and as a natural sequence his society will be a better society. As you desire and labor for the cooperation of your members, so do the officers of your state society desire *your* cooperation in this work and to make this meeting a potent factor in bringing about a better, larger, more influential state society. Again, you will be looked for on September 3, at 3:00 p. m.

Public Health

Conducted by

ROBERT L. DIXON, M.D.

Secretary Michigan State Board of Health

OPHTHALMIA NEONATORUM

The subject of blindness is of no small importance, not only from the scientific and sentimental points of view, but from the economic aspect as well. Blindness is admitted by all to be one of the most severe afflictions possible to the human body. None of us knows how prevalent this affliction is among the people of Michigan. The records of such conditions are incomplete and undoubtedly show far short of the real situation. The school census of 1911 returned 487 children who were totally blind or whose vision was so impaired as to prevent their attending the public schools. Less than one-third of these could be accommodated at the State School for the Blind. The new buildings provided for by the recent legislature will make it possible to take care of many more than heretofore.

I am informed by the superintendent of the State School for the Blind that from his study of the certificates accompanying the children entering that institution, he finds *32 per cent. are reported as being blind from birth.*

Dr. F. Park Lewis, President of the National Association for the Prevention of Blindness and Conservation of Vision, says: "There are in the state of New York somewhat more than six thousand blind people (not including the still larger number who have lost only one eye). It is the accepted conclusion of those who have carefully studied the question, that of these, had proper measures been taken in the way of prevention and of good care and correct treatment, one-third surely should never have lost their sight, and that the eyes in two-thirds of these cases might have been saved. The blindness in only one-third of the cases was considered abso-

lutely inevitable, and, had the principle of eugenics been practically applied, in even some of these cases, blindness would not have occurred."

It is not to be doubted that preventable blindness exists in at least as large proportions among the citizens of Michigan. Not a few of these cases must be charged to the negligence of physicians in their failure to apply well-known and decidedly simple prophylactic methods. It is true that we place some of these cases against the untrained, uncontrolled midwife, but the health officer of one of our largest cities recently stated that of all the cases of ophthalmia neonatorum coming to his attention, by much the larger per cent. were in the practice of physicians, even when taking into consideration the number of obstetrical cases managed by physicians as compared with those handled by midwives.

Be those points as they may, it is beyond dispute that the blinded child and society as a whole pay too great a price for the failure to conserve the most precious of the several senses.

Ophthalmia neonatorum has recently been declared by the State Board of Health to be "a dangerous communicable disease," and as such physicians are required by law to report their cases to the local health department.

The Michigan legislature, at the last session, made a law in relation to this subject. The full text of the law (Act 123, Public Acts, 1913) follows:

"Section 1. It shall be the duty of the State Board of Health to officially name and approve a prophylaxis, to be used in treating the eyes of newly-born infants, and it shall be the duty of the Board to publish instructions for using the same.

"Section 2. It shall be the duty of any physician, nurse or midwife who shall assist and be in charge at the birth of any infant or have care of the same after birth, to treat the eyes of the infant with a prophylaxis approved by the State Board of Health; and such treatment shall be given as soon as practicable after the birth of the infant and always within one hour; and if any redness, swelling, inflammation or gathering of pus shall appear in the eyes of such infant or on the lids or about the eyes within two weeks after birth, then any nurse, midwife or other person having care of the infant shall report the same to some competent practicing physician within six hours of its discovery.

"Section 3. Any failure to comply with the provisions of section two of this act shall be punishable by a fine not to exceed one hundred dollars, or imprisonment in the county jail not

to exceed six months, or both such fine and imprisonment in the discretion of the court."

By another enactment the birth certificate must bear the statement that the infant's eyes were treated as required by the statute first cited.

Complying with Section 1, Act No. 123, the State Board of Health officially names and approves as a prophylaxis to be used in treating the eyes of newly-born infants, *2 per cent. silver nitrate solution*. The eyes are to be first washed with physiologic salt solution or with boric acid solution, after which *one drop of 2 per cent. silver nitrate solution* is to be instilled in each eye.

This act takes effect August 14, 1913.

New and Nonofficial Remedies

Since publication of New and Nonofficial Remedies, 1912, and in addition to those previously reported, the following articles have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association for inclusion with "New and Nonofficial Remedies":

SOLUTION AMYLENE-CHLORAL (50 PER CENT) KALLE. A 50 per cent. solution of amylene chloral, a combination of chloral with amylene hydrate. It is soluble in alcohol, but insoluble in water. Its actions are much like those of chloral, but with less power to abolish the reflexes and less irritating. Merck & Co., New York *Jour. A. M. A.*, June 14, 1913, p. 1881).

PITUITARY LIQUID.—Pituitary liquid is a sterile solution containing the active principle of the posterior lobe of the pituitary body of the ox. Each cubic centimeter represents 0.2 gm. of the fresh posterior lobe of the pituitary body in physiologic salt solution. It is said to be useful in cases requiring stimulation of the heart or raising of the arterial tension. It is claimed to be valuable in paralytic distension of the intestines and in postoperative and other pareses as well as in promoting uterine contractions during labor. It is supplied as Ampoules Pituitary Liquid, 1 c.c. Armour & Co., Chicago, Ill. (*Jour. A. M. A.*, June 21, 1913, p. 1957.)

LUMINAL TABLETS, 1½ GRS.—Each tablet contains luminal 0.1 gm. Merck & Co., New York. (*Jour. A. M. A.*, June 21, 1913, p. 1957.)

LUMINAL TABLETS, 5 GRS.—Each tablet contains luminal 0.3 gm. Merck & Co., New York. (*Jour. A. M. A.*, June 21, 1913, p. 1957.)

EMETINE HYDROCHLORIDE.—Emetine Hydrochloride is the hydrochloride, $C_{30}H_{44}N_2O_5 \cdot 2HCl \cdot 2H_2O$, of an alkaloid found in ipecac. It occurs as a white crystalline powder, soluble in water yielding a neutral solution. Emetine Hydrochloride acts similarly to ipecac but is relatively more nauseant and less emetic, and causes relatively less renal irritation, but more cardiac depression. Emetine Hydrochloride in the form of injections has been reported to be of especial value in amebic dysentery.

EMETINE HYDROCHLORIDE, MERCK.—Merck & Co., New York.

AMPULS EMETINE HYDROCHLORIDE, MULFORD.—Each ampul contains emetine hydrochloride 30 mg. H. K. Mulford & Co., Philadelphia, Pa. (*Jour. A. M. A.*, July 5, 1913, p. 27.)

ACNE VACCINE.—For description of Acne Vaccine see N. N. R., 1913, p. 221. Greeley Laboratories, Inc., New York City.

COLON VACCINE.—For description of Bacillus Coli Vaccine see N. N. R., 1913, p. 221. Greeley Laboratories, Inc., New York City.

PYOCYANEUS VACCINE.—For description of Bacillus Pyocyaneus Vaccine see N. N. R., 1913 p. 222. Greeley Laboratories Inc. New York City.

GONOCOCCUS VACCINE.—For description of Gonococcus Vaccine see N. N. R., 1913, p. 223. Greeley Laboratories, Inc., New York City.

MENINGOCOCCUS VACCINE.—For description of Meningococcus Vaccine see N. N. R., 1913, p. 223. Greeley Laboratories, Inc., New York City.

PNEUMOCOCCUS VACCINE.—For description of Pneumococcus Vaccine see N. N. R., 1913, p. 224. Greeley Laboratories, Inc., New York City.

STAPHYLOCOCCUS ALBUS VACCINE.—Greeley Laboratories, Inc., New York City.

STAPHYLOCOCCUS AUREUS VACCINE.—For description of Staphylococcus Vaccine see N. N. R., 1913, p. 225. Greeley Laboratories, Inc., New York City.

STREPTOCOCCUS VACCINE.—Greeley Laboratories, Inc., New York City.

STREPTOCOCCUS ERYSIPELATIS VACCINE.—For description of Streptococcus Vaccine see N. N. R., 1913, p. 226. Greeley Laboratories, Inc., New York City.

TYPHOID BACILLUS VACCINE.—For description of Typhoid Bacillus Vaccine see N. N. R., 1913, p. 227. Greeley Laboratories, Inc., New York City.

TUBERCULIN B. E.—For description of New Tuberculin, Koch, Bacilli Emulsion ("B. E.") see N. N. R., 1913, p. 233. Greeley Laboratories, Inc., New York City. (*Jour. A. M. A.*, July 5, 1913, p. 27.)

DIPLOSAL.—Diplosal is the salicylic ester of salicylic acid, $HO \cdot C_6H_4 \cdot COO \cdot C_6H_4 \cdot COOH$. It is white, almost tasteless and almost insoluble in water. While diplosal is insoluble in dilute acid, it is soluble in alkaline liquids with gradual liberation of salicylic acid; accordingly, it passes the stomach unchanged, but is readily absorbed in the intestine. Diplosal may be used where salicylic acid or salicylic acid derivatives are indicated. It is marketed as a powder and in tablets.

DIPLOSAL TABLETS, 7½ GRS.—Each tablet contains 0.5 Gm. diplosal. Merck & Co., New York (*Jour. A. M. A.*, July 12, 1913, p. 121).

The Truth About Medicines

It is the purpose of this department to encourage honesty in medicines, to expose frauds and to promote rational therapeutics. It will present information regarding the composition, quality and value of medicaments, particularly as this is brought out in the reports of the Council on Pharmacy and Chemistry and of the Chemical Laboratory of the American Medical Association.

RESPIRAZONE.—The manufacturers of Respirazone—The Tilden Company—publish an incomplete and therefore meaningless "formula." It is said to be composed of "Iodid and Bromid of Potassium, Helianthus Annuus [Sunflower], Ipecacuanha, Lobelia Inflata [Lobelia], and Leonorus Cardiaea [Motherwort]." Taken even at its face value, Respirazone evidently is a nostrum of the shot-gun prescription type, containing, as is usually the case, some obsolete or worthless drugs. The unreliability of the Tilden Company has been shown by the examination in the A. M. A. Chemical Laboratory of "Hydrocyanate of Iron, Tilden," and by the prosecution by the federal government for misbranding its "Febrisol." (*Jour. A. M. A.*, June 14, 1913, p. 1899).

STAPHYLOCOCCUS VACCINE.—A pure culture of *Staphylococcus aureus*, recently isolated, should be used for the preparation of this vaccine. The "polyvalent" vaccine strains consisting of a mixture of different staphylococci have not been found superior to that of *S. aureus*, alone. The stock vaccine has proved useful in the treatment of chronic furunculosis, sycosis and eczema. It is less valuable in the treatment of acne. (*Jour. A. M. A.*, June 21, 1913, p. 1955.)

STREPTOCOCCUS VACCINE.—The field of usefulness of stock vaccine of *Streptococcus* is limited. This is due to the large number of strains and varieties which exist. The use of "polyvalent" vaccines is of no avail. While awaiting response to the stock vaccine, the preparation of an autogenous vaccine should be begun. The stock vaccine should be made from *Streptococcus pyogenes*. (*Jour. A. M. A.*, June 21, 1913, p. 1955.)

THIOCOL AND SYRUP THIOCOL, ROCHE.—Seven years ago the Council on Pharmacy and Chemistry accepted Thiocol, potassium guaiacol sulphonate, for inclusion with New and Nonofficial Remedies and more recently also a preparation of it, Syrup Thiocol, Roche. Recently the Council was advised that the product, in the form of a syrup called Sirolin, was being advertised to the public, both in this country and abroad under grossly exaggerated claims. In view of the well-established fact that the most important of all factors in the cure of consumption consists in an early and accurate diagnosis, followed by general treatment, the Council considers that the advertising of a syrup of Thiocol, under the name "Sirolin," involves not merely a serious infringement of its rules, but a menace to the public. After submitting the facts to the manufacturers, the Council voted to delete Thiocol and Syrup Thiocol, Roche, from New and Nonofficial Remedies. (*Jour. A. M. A.*, June 21, 1913, p. 1974.)

THE SARSAPARILLA FETISH.—Twenty years ago sarsaparilla was regarded by the medical profession as a remedy of value. To-day it is never prescribed by the discriminating physician—although it is still one of the standard ingredients in many worthless "patent-medicines." Replying to a request to furnish a formula for a "compound extract of sarsaparilla" the Druggists' Circular for May says: "We can, but know of no reason why we should, and do not believe that we shall." After recommending the separation of the nostrum business from that of the pharmacist's vocation it is suggested: "Fakers will fake; they don't seem to care; but druggists, as followers of an honorable calling, cannot afford to play grim jokes on trustful seekers after health." (*Jour. A. M. A.*, June 21, 1913, p. 1975.)

BACTERIAL VACCINES.—A discussion of the indications and limitations of bacterial vaccine therapy is presented by a committee appointed by the Council on Pharmacy and Chemistry. Vaccine therapy is a highly specialized field of medicine whose successful pursuit calls for a particular training in bacteriology, immunology and clinical medicine. The therapeutic possibilities of vaccine therapy have been exaggerated. The promiscuous use of the stock bacterial vaccines of commerce in the treatment of acute and chronic infections is an irrational procedure. Ready-mixed commercial vaccines should be abolished. In cases suitable for bacterial therapy, autogenous vaccines are with few exceptions superior. Autogenous vaccines should be prepared by those in touch with the patient and not through the agency of remote laboratories. (*Jour. A. M. A.*, June 28, 1913, p. 2046.)

PHYSICIANS AND THE PHARMACOPOEIA.—Believing that it is the province of the medical profession to designate the drugs that shall be included in the Pharmacopoeia, the Section on Pharmacology, at the recent meeting of the A. M. A., adopted the following resolution: "Resolved, That the section request the House of Delegates of the American Medical Association to urge on the Committee of Revision of the Pharmacopoeia of the United States that the selection of articles to be included be left to the Committee on Scope, in which the medical profession has a majority representation, rather than to the Executive Committee, which represents mainly the pharmaceutical profession, and which has overridden half the changes advocated by the Committee on Scope." The resolution was endorsed by the House of Delegates. (*Jour. A. M. A.*, June 28, 1913, p. 2086.)

PURE DRUGS.—With a view of emphasizing the need of a more vigorous enforcement of laws, federal and state, relating to pure drugs, the Section on Pharmacology at the recent meeting of the A. M. A. adopted the following motion: "Resolved, That the Section on Pharmacology and Therapeutics requests the House of Delegates of the A. M. A. to bring this matter to the attention of the proper federal and state authorities, and urge on them the need for more energetic and effective action in this direction." The motion was endorsed by the House of Delegates, which also advised that the matter of securing the enforcement of state laws should be taken up by the individual state associations. (*Jour. A. M. A.*, June 28, 1913, p. 2086.)

THE COUNCIL ON PHARMACY AND CHEMISTRY.—Torald Sollmann reviews the preliminary work of the Council on exposing the abuses which had crept into the exploitation and marketing of proprietary medicines and outlines its present efforts to bring about a more rational use of medicines, as illustrated by the issuance of a book on "Useful Remedies" and publication of a series of articles on the possibilities and limitations of vaccine therapy. In discussing the results of the work, Sollmann points out that while conditions are not as they should be, they have improved vastly. Secret nostrums, worthless remedies, blatant advertisements and extravagant claims have not been suppressed and while some frauds have sunk into oblivion others have arisen. It is significant, however, that new nostrums are not appearing at the former rate. Remedies are used with more discretion. Testimonials of worthless drugs are not given with the liberality by careless, if well-meaning phy-

sicians; the tone of the advertisements has become much less extreme, the claims much more conservative. All this means that the profession is more critical, less inclined to believe that the latest advertised fad must be best; less reliant on biased manufacturers as the exclusive source of therapeutic information. The interest in exact therapeutic observation and experiment is much greater. The teaching of these subjects in our medical schools has vastly improved. (*Jour. A. M. A.*, July 5, 1913, p. 5.)

CARELESSNESS IN PHARMACY.—M. I. Wilbert tabulates the reports of federal and state authorities on the quality of pharmaceutical products found in pharmacies. The large proportion of unsatisfactory products found he ascribes to indifference or carelessness engendered by the countless variety of medicinal preparations which the pharmacist must keep in stock. He believes that in a shop devoid of "side-lines," that is, equipped with the necessary analytical apparatus, it would be possible to exercise efficient control over a reasonable number of well-defined medicaments. He thinks that a more restricted materia medica will do much to improve the quality of drugs (*Jour. A. M. A.*, July 19, 1913, p. 189).

TOXIC EFFECT OF LUMINAL.—Two cases are reported which seem to show that the use of Luminal is likely to lead to some difficulty when repeated doses are given. In the cases reported the action of the drug did not make itself manifest until an accumulative reaction had set in, which then produced untoward symptoms. The maximum dose, 0.8 Gm., given by the manufacturers, should not be exceeded (*Jour. A. M. A.*, July 19, 1913, p. 192).

KEEPING QUALITIES OF DIGITALIS AND ITS PREPARATIONS.—The strength of digitalis and digitalis preparations depends on their keeping qualities and on the manner in which these have been treated or prepared. As the crude drug varies considerably, digitalis preparations should be made from physiologically assayed drugs. Fluidextract of digitalis is difficult to prepare and generally unreliable, as is also the pseudo-tincture made therefrom. Preparations containing little alcohol, as the infusions, are likely to deteriorate. The low alcohol content of digitalis may explain its variability. The wide-spread view that digitalis leaves, fluidextract and tincture of digitalis are prone to rapid deterioration is unfounded (*Jour. A. M. A.*, July 19, 1913, p. 202).

MISBRANDED DRUG PREPARATIONS.—The federal authorities have issued "Notices of Judgment" for misbranding under the Food and Drugs Act in regard to the following: Denton's Healing Balsam, Allen's Compound Extract of Damiana, Hamburg Stomach Bitters, Dr. Bennett's Wonder Oil, and Pale Orange Bitter (*Jour. A. M. A.*, July 19, 1913, p. 211).

CASOID FLOUR.—J. P. Street having stated that Casoid Flour, an article accepted for New and Non-official Remedies, contained 2.2 per cent. carbohydrates, the secretary of the Council on Pharmacy and Chemistry states that the article was free from sugar and starch when accepted by the Council, and that a specimen recently examined in the Association's laboratory was also found free from sugar and starch (*Jour. A. M. A.*, July 19, 1913, p. 212).

NUTRIENT ENEMA.—The daily urinary nitrogen output of patients receiving enema of eggs or milk "peptonized" a few minutes failed to give evidence of more

than traces of absorbed protein products. Amino-acids prepared from milk by digestion for twenty-four hours with a vigorous pancreatic enzyme were apparently well absorbed. Dextrose was absorbed better than lactose and checks the losses due to inanition. For patients suffering from gastric ulcer, useful enemas can be prepared by vigorous pancreatic predigestion of milk, with subsequent addition of 5 per cent. of dextrose (*Jour. A. M. A.*, July 12, 1913, p. 123).

THE TOXICITY OF DIPLOSAL.—Dr. John MacLachlan reports clinical tests which show that, contrary to the claim of the manufacturer, Diplosal, if given in the same manner as other salicylates, produces the same symptoms of toxicity and with equal severity. The drug was administered by mouth in capsules. The tests show that not only is Diplosal toxic, but smaller doses suffice to produce the toxic effects than are required with sodium salicylate. While the average toxic dose for sodium salicylate was found to be 190 grains, the toxic dose of Diplosal was found to be 92.2 grains (*Jour. A. M. A.*, July 12, 1913, p. 116).

DIPLOSAL.—Diplosal, salicyl-salicylic acid, has been marketed with the claim that it does not produce gastric and other "toxic" effects of salicylic compounds. As this claim was questionable, Dr. John MacLachlan made, for the Council on Pharmacy and Chemistry, a series of clinical tests which showed that Diplosal produced the toxic as well as the antirheumatic effects in approximately half the dose of sodium salicylate. A similar series of tests made in Germany for the manufacturer of Diplosal also showed toxic effects, but from them it appeared that the toxicity was less than that of sodium salicylate. The manufacturer of Diplosal having agreed to give publicity to the results of Dr. MacLachlan, as well as to those obtained in Germany, the Council voted to accept Diplosal for inclusion with New and Nonofficial Remedies (*Jour. A. M. A.*, July 12, 1913, p. 121).

SERUM TREATMENT OF MENINGITIS.—After years of study the Rockefeller Institute has issued a report on the treatment of epidemic meningitis. From the available records of the mortality of the epidemics which prevailed in the United States and Canada in 1904 to 1909 and in the winters of 1911 to 1913, the record of fatalities is above 70 per cent. Similarly the epidemics in foreign countries have given a death rate above 70 per cent. The analysis of the results in 1,300 cases treated with serum supplied by the Rockefeller Institute shows that the mortality of epidemic meningitis can be greatly reduced by the serum treatment. While the average mortality during the pandemic was 70 per cent., that in the serum treatment cases was about 30 per cent. The success of the treatment depends on the age of the patient and the period of the disease when the subdural injections are begun (*Jour. A. M. A.*, July 26, 1913, p. 281).

ENESOL.—Enesol has been claimed to be a salicyl arsenate of mercury, a molecular combination of monomethyl arsinic acid and a double salicylate of mercury and sodium, but no definite formula for the compound has been furnished. Enesol was considered by the Council on Pharmacy and Chemistry and refused recognition because the origin and composition were not given, because the manufacturer had made misstatements regarding the identity of the preparation, and because the advertised composition did not agree with that found by analysis in the Association's laboratory (*Jour. A. M. A.*, July 26, 1913, p. 293).

CLINICAL EFFECTS OF "NATURAL" AND "SYNTHETIC" SODIUM SALICYLATE.—A critical study of the literature, a pharmacologic investigation and comprehensive chemical analyses have shown that the claim for superiority of the "natural" sodium salicylate over the "synthetic" kind is not warranted by the evidence. While these investigations all indicate that no difference exists between the two varieties of sodium salicylate, it was agreed that clinical tests were required definitely to decide the point. Accordingly the Council, with the aid of clinicians of recognized standing with hospital facilities at their disposal, undertook a comprehensive clinical comparison of the effects of the two kinds of sodium salicylate. The results of this investigation have been compiled by Dr. A. W. Hewlett and they show that "natural" and "synthetic" sodium salicylate are indistinguishable so far as their therapeutic and toxic effects on patients are concerned (*Jour. A. M. A.*, Aug. 2, 1913, p. 319).

Book Notices

THE PRACTICAL MEDICINE SERIES, Volume IV. Gynecology, edited by E. C. Dudley and H. M. Stowe. Series 1913. Cloth. 229 pages. The Year Book Publishers, 327 La Salle Street, Chicago, Ill. Price, \$1.35. Series price, \$10.00.

The year's progress in gynecology is covered in a satisfactory manner and the premises laid down in various papers published during the year are constantly abstracted and commented on. The work should prove of value to the practitioner, for it will enable him to remain conversant with the progress that has been made in this specialty.

THE PRACTICAL MEDICINE SERIES, comprising ten volumes on the year's progress in Medicine and Surgery. Volume III. The Eye, Ear, Nose and Throat. Edited by Casey A. Wood, M.D.; H. A. Andrews, M.D.; Gustavus P. Head, M.D. Series 1913. The Year Book Publishers, 327 La Salle Street, Chicago, Ill. Price, \$1.50. Series Price, \$10.00.

The general practitioner desirous of remaining conversant with the progress made in the diseases of the specialty to which this volume is devoted will find in this edition much of profit, practicability and instruction. The work is one that will enable the busy doctor to remain in touch with this specialty and should prove to be of great assistance. It has covered the field rather thoroughly and the important subjects are well handled.

DIET LISTS OF THE PRESBYTERIAN HOSPITAL, NEW YORK CITY. Compiled, with notes, by Herbert S. Carter, M.D., assistant visiting physician to the Presbyterian Hospital, associate in medicine at Columbia University, etc. 12mo of 129 pages. Philadelphia and London: W. B. Saunders Company, 1913. Cloth, \$1 net.

Dietetics deservedly occupies a prominent place in the treatment of the sick. It merits more attention than is frequently given. The needs of a patient laid up with a broken leg and one recovering from an

acute wasting or infectious disease are different. What shall we feed the patient? This little book answers the question very, very satisfactorily and efficiently. It will answer it for the physician very readily and without the necessity of wading through page after page of the text. A welcome and a very valuable addition to a physician's library, or rather, desk reference books, is what this Diet List should prove. You must see it to appreciate it and seeing it, you will want it. You cannot invest a dollar to better advantage.

LABORATORY METHODS, WITH SPECIAL REFERENCE TO THE NEEDS OF THE GENERAL PRACTITIONER. By R. G. R. Williams, M.D., and E. G. C. Williams, M.D. With introduction by Victor C. Vaughan, M.D., LL.D. Second edition, Cloth, 210 pages, 43 engravings. C. V. Mosby Co., St. Louis, Mo. Price, \$2.50.

As a rule the general practitioner is not prepared to make elaborate chemical tests and examinations. It is not presumed that the practitioner shall attempt every investigation or laboratory examination. There are, however, many comparatively simple examinations, which may be made by him. This volume gives to the general practitioner simple methods and apparatus for the conducting of these laboratory analyses. Only the best tests are given. The volume also shows how the general practitioner can, at a very small cost, equip a laboratory in which he can do most excellent work. The reviewer is pleased to commend the work and the form in which it is gotten out. It is a valuable laboratory guide; up to date and merits a cordial reception.

MESSAGE—ITS PRINCIPLES AND TECHNIC. By Max Bohm, M.D., of Berlin, Germany, edited, with an introduction, by Charles F. Painter, M.D., professor of Orthopedic Surgery at Tuft's Medical School, Boston. Octavo of ninety-one pages, with ninety-seven illustrations. Philadelphia and London: W. B. Saunders Company, 1913. Cloth, \$1.75 net.

Physical therapeutics should be employed more than it is. We are not securing for our patients the benefits they might receive, because many of us do not know of the advantages that are inherent in these various physical therapeutic measures. This volume will enable the reader to become familiar with the technic of massage. The technic is exactly that which is employed in Hoffa's clinic. It is amply and clearly illustrated. The principles are described step by step. The book is of value to physicians, nurses, and those pursuing courses in medical gymnastics. We are making a mild statement when we say: this volume cannot but be of incalculable value to every possessor and as such merits the earnest consideration of every practitioner to the extent that he purchase it, study it and apply its teachings.

BLOOD-PRESSURE. From the Clinical Standpoint. By Francis Ashley Faught, M.D., of the Medico-Chirurgical College, Philadelphia. Octavo of 281 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1913. Price \$3 net.

The last few years have marked a rapid rise in the clinical value of the sphygmomanometer. This instru-

ment is now a part of the armamentarium of the physician. It is therefore proper that a book, gotten out in concise form as this one is, giving a résumé of the clinical and experimental work and the pith of the medical literature on the subject of blood-pressure should make its appearance at this opportune time. He who desires to use the pressure instrument and interpret its readings must have in his possession the details, facts, principles and diagnostic interpretations, all of which may be secured by the study of this volume. Every relation of blood-pressure to disease and abnormal conditions is well discussed and clearly enunciated. The progressive practitioner will find in this work a book that he will do well to secure and with which he will be enabled to make correct deductions from his blood-pressure observations.

SURGICAL OPERATIONS WITH LOCAL ANESTHESIA. By Arthur E. Hertzler, M.D., Surgeon to the Halstead Hospital, Halstead, Kan., and to the Swedish Hospital, Kansas City, Mo. 250 pages. Cloth. Illustrated, marginal reference notes. Surgery Publishing Company, 92 Williams street, New York, N. Y. Price, \$2.00.

The surgeon and general practitioner who works without the advantages of hospital facilities, as well as he whose minor surgery is done in his private office or at the home, will find in this work much useful and practical information. Local anesthesia is being employed more and more frequently, and as its advantages become more apparent and thus appeal to the good judgment of the surgeon, definite technic is being developed and definite indications for its employment are being pointed out.

To him who desires to become familiar with this technic this volume should prove of estimable value. It covers every phase of the subject in detail and imparts all the necessary knowledge requisite for one who desires to employ local anesthesia effectively and safely.

This volume should prove to be a valuable addition to every practitioner's library.

INTERNATIONAL CLINICS. A quarterly of illustrated clinical lectures and especially prepared original articles on Treatment, Medicine, Surgery, Neurology, Pediatrics, Obstetrics, Gynecology, Orthopedics, Pathology, Dermatology, Ophthalmology, Otology, Rhinology, Laryngology, Hygiene and other topics of interest to students and practitioners. Edited by H. W. Cattell, M. D., Philadelphia. Volume ii, twenty-third series, 1913. J. B. Lippincott Company, Philadelphia. Cloth. Price \$2.00.

Maintaining its high standard and value, this volume of the International Clinics merits a very cordial reception. Of especial interest is the article on the Therapeutic Indications for Antitoxins, Serums and Vaccine. This is a subject that is rapidly becoming of vital importance and he who is desirous of knowing the important indications for serum therapy will find Dr. Illman's article very instructive, as is also the article on Therapy Under Modern Biology. The review of A Year's Fracture Work, covering 299 cases, will find particular favor with those whose practice contains a very large number of fracture cases. To review the work would necessitate considering every article. This the reviewer has not the space for. The series is commended to every one of our readers. You cannot well miss them.

PROGRESSIVE MEDICINE. A quarterly digest of the Advances, Discoveries and Improvements in the Medical and Surgical Services. Vol. xv, No. 2, Whole No. 58. Herbert Amory Hare, M.D. June, 1913. Lea & Febiger, Philadelphia. \$6.00 per annum.

This volume of this valuable and popular publication is devoted to Hernia, Surgery of the Abdomen, Gynecology, Diseases of the Blood, Diathetic and Metabolic Diseases, Diseases of the Spleen, Thyroid Gland, Nutrition, and the Lymphatic System and Ophthalmology.

To one desirous of remaining abreast of the progress made in the above branches of the work of the profession, we cannot conceive how he can afford to be without this series. Every article is of value and extremely to the point, giving the reader a condensed opinion on each subject. The chapter on hernia and the surgery of the stomach and intestines deserves especial mention, as does also the chapters on cancer of the uterus and the blood. The forty pages devoted to ophthalmology, edited by Edward Jackson, cannot receive anything but commendatory praise. A progressive volume in every sense, that appeals at once to the progressive surgeon or practitioner.

MASSAGE, MANUAL TREATMENT, REMEDIAL MOVEMENTS, HISTORY, MODE OF APPLICATION AND CONTRA-INDICATIONS. By Douglas Graham, M.D., Boston, with chapter on Massage of the Eye, by A. Darier, M.D., Paris. Fourth edition; 75 illustrations; 566 pages. Cloth. J. B. Lippincott Co., Philadelphia.

The success attendant on the first three editions of this work has called forth a fourth edition; thoroughly revised, modern and maintaining many commendatory features of former editions as well as adding new and valuable features. This is a work which we wish every practitioner would read. Mechanotherapy and massage are distinct, valuable agents in the treatment of disease. They meet definite indications and accomplish definite ends. Conversant with the principles of massage on the part of the individual doctor and the institution of massage treatment in given conditions would bring about a movement that would do away with many of the new cults that have arisen. This book is of scientific merit and much practical use. It is full of clearly expressed directions to guide the uninitiated. Of all books on the subject, this one is probably the best. Again we say, it should be read by every physician in Michigan.

DISEASES OF THE EYE. By George E. deSchweinitz, M.D., professor of Ophthalmology in the University of Pennsylvania. Seventh edition, thoroughly revised. Octavo of 979 pages, 360 text illustrations, and seven lithographic plates. Philadelphia and London: W. B. Saunders Company, 1913. Cloth, \$5 net. Half Morocco \$6 net.

The seventh edition of this work will be welcomed by the profession, who have always known it to be a book which they could not well do without. This revision makes it more valuable than ever. Its various chapters have been revised carefully and a certain amount of new matter has been incorporated. Thus, special paragraphs on the following subjects appear for the first time: Schiötz's Tonometer; Ophthalmodiaphanoscopy; Sporotrichosis of the Eyelids and

Conjunctiva; Widmark's Conjunctivitis; Rosacea Keratitis; Epithelial Dystrophy of the Cornea; Marginal Degeneration of the Cornea; Blue Sclerotics; Progressive Atrophy of the Iris Layers; Exudative Retinitis (Coat's disease); Angiomatosis Retinae (von Hippel's disease); Cysts of the Retina; Blindness from the Arylarsonates; Siegrist's Method of Local Anesthesia; Simple Trephining of the Sclera (Elliott's operation); Reese's Muscle Resection Operation; Toti's Operation (Dacryocystorhinostomia).

Wherever necessary, due reference has been made to recent uses of vaccine therapy; for example, in gonorrheal iritis, to the indications for the administration of salvarsan in ocular disorders, and to the septic (bacterial) origin of iritis and uveitis. In brief, an endeavor has been made to include the important discoveries and observations of the last three years.

DISEASES OF THE STOMACH, including Dietetic and Medicinal Treatment. By George Roe Lockwood, M.D., professor of Clinical Medicine in Columbia University, and attending physician to Bellevue Hospital, N. Y. Cloth; 624 pages; 126 engravings; 15 plates. Lea & Febiger, Philadelphia.

This is a work that is based on a large clinical experience and is a compilation of the observations made by the author. It is a description of the diseases of the stomach as he has happened to see them. When his observations are at variance with the accepted teachings, the fact is noted, the opposing views are given fair discussion, but the case analysis has not been changed to comply with the accepted pre-existing views. It therefore makes this a work of exceptional value and places before the reader a large series of cases and histories and findings. It is not a compilation of the opinions of others, but an analysis of the diseases of the stomach as they have been seen by the author. This, then, should make the work of particular value to the practitioner and also to him who devotes his entire time to the treatment of gastric diseases. Dietetic and medicinal treatment is carefully considered and fully discussed in every instance. The publishers are deserving of a large patronage for producing such an excellent volume.

THE MODERN TREATMENT OF NERVOUS AND MENTAL DISEASES. By eminent American and British authors. Edited by William A. White, M.D., superintendent of the Government Hospital for the Insane, Washington, D. C.; professor of Nervous and Mental Diseases in the Georgetown University and in the George Washington University; lecturer on Mental Diseases in the U. S. Army and U. S. Navy Medical School, Washington, D. C., and Smith Ely Jelliffe, A.M., M.D., Ph.D., Adjunct Professor of Diseases of the Mind and Nervous System in the Post Graduate Medical School and Hospital; visiting neurologist to the City Hospital; consulting neurologist to the Manhattan State Hospital, New York, N. Y. Two octavo volumes, containing about 900 pages each, illustrated. Per volume, cloth, \$6, net. Lea & Febiger, publishers, Philadelphia and New York, 1913.

The second volume of this unique work has made its appearance within a few weeks after the publication of the first. It deals with matters of great interest and extreme practical value, and its pictorial

department is fully up to the high standard of the text. Among the many subjects discussed are the Neuralgias and Neuritides, Injuries of the Peripheral Nerves, Muscular Atrophies and Dystrophies, Headaches, Spasmodic Disorders, Epilepsies, the Meningitides, Syphilitic Diseases of the Nervous System, the Use of Salvarsan and Neosalvarsan, Cerebral Hemorrhage, Embolism and Thrombosis, Disorders of Expression, Stuttering and Diseases of the Cranial Nerves and Lesions of the Spinal Cord, Diseases of the Optic Thalamus, Midbrain and Cerebellum, Paralysis Agitans and Multiple Sclerosis, the Toxemias of the Dangerous Trades and of Drugs, and the Surgery of the Brain and Spinal Cord. In these two volumes the practitioner now has, in the most convenient form, the latest and best knowledge concerning a very puzzling and difficult class of cases. We know of no work that so fully meets the needs and requirements of the general practitioner.

DISEASES OF THE EAR. By Phillip D. Kerrison, M.D., Professor of Otology, New York Polyclinic Medical School and Hospital; Junior Aural Surgeon to the Manhattan Eye, Ear and Throat Hospital; Aural Surgeon to the Willard Parker Hospital for Infectious Diseases, etc. 331 Illustrations in the Text and two full pages in color, 1913. J. B. Lippincott Company, Philadelphia and London. Price, \$5.00.

Otology has probably witnessed more advance in the past decade than any other branch of medicine, and is progressing now even more rapidly. Aurists no longer confine themselves to the tympanum and mastoid. Study of the labyrinth has added a large field; autogenous vaccines have added their problems, and meningeal and brain surgery have increased the field of the aurist to no small extent. Kerrison has attempted to present the diseases of the ear in the light of our recent advances and present tendencies. He has eliminated many discarded but historically important theories and methods of treatment, and has substituted such of the new as has been found of value.

Anatomy and physiology are allotted forty pages. Examinations of the patient and functional examinations of the ear are important and occupy fifty-six pages, the methods and instruments used being carefully described.

The labyrinth occupies sixty-two pages of text and is illustrated by forty cuts. The treatment is comprehensive. Speaking of the treatment of diffuse suppurative labyrinthitis Kerrison distinctly points out that the disease *per se* is not fatal; that fatal endings are due to intracranial complications, and our diagnostic skill should be directed to determining whether meningeal involvement is imminent.

The chapters on surgical treatment are especially well illustrated both as to instruments necessary, and the steps of the operation. Brain surgery, tuberculosis, syphilis, non-suppurative diseases of the labyrinth, adenoids, salvarsan, vaccine and serum therapy, dental lesions and deafmutism all receive appropriate attention.

In the appendix is considered aural diseases in relation to life insurances, artificial aids to hearing, case histories, etc. A most complete and valuable book.